STOP-Bang Questionnaire

1. Snoring
Do you *snore* loudly (louder than talking or loud enough to be heard through closed doors)?
☐ Yes ☐ No

2. Tired
Do you often feel *tired*, fatigued or sleepy during daytime?
☐ Yes ☐ No

3. Observed
Has anyone observe you *stopping* breathing during your sleep?
☐ Yes ☐ No

4. Blood pressure
Do you have or are you being treated for high blood pressure?
☐ Yes ☐ No

5. BMI
Is your BMI ≥ 30?
☐ Yes ☐ No

6. Age
***Are you* over 50 years old?**
☐ Yes ☐ No

7. Neck Circumference
Is your *neck* circumference ≥ 17 inches
☐ Yes ☐ No

8. Gender
Are you a male?
☐ Yes ☐ No

----------PLEASE FOLD HERE BEFORE GIVING TO PATIENT----------

SCORING

HIGH RISK OF OSA –' YES' TO THREE OR MORE ITEMS
LOW RISK OF OSA – 'YES' TO LESS THAN THREE ITEMS

Source: Chung, F., Yegneswaran, B., Liao, P., Chung, S. A., Vairavanathan, S., Islam, S., Khajehdehi, A., and Shapiro, C. M. STOP Questionnaire A Tool to Screen Obstructive Sleep Apnea. Anesthesiology 108, 812-821. 2008.