Pulmonary and Sleep Associates of Marin

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Patient Name:

DOB:

STOP-BANG SLEEP APNEA QUESTIONNAIRE

Do you **S**NORE loudly? (louder than talking or loud enough to be heard through closed doors)	Yes	No
Do you often feel **T**IRED, fatigued or sleepy during the daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No

BMI more than 35 kg/m2 ?	Yes	No
AGE over 50 years old ?	Yes	No
NECK circumference > 16 inches (40 cm)	Yes	No
GENDER male ?	Yes	No

HIGH risk of OSA: Yes 5-8
MODERATE risk of OSA: Yes 3-4
LOW risk of OSA: Yes 0-2