THE STOP-Bang Questionnaire

A Tool to Screen Patients for Obstructive Sleep Apnea (OSA)

1. Do you **S**nore loudly (louder than talking or loud enough to be heard through closed doors)?

   Yes No

2. Do you often feel **T**ired, fatigued, or sleepy during daytime?

   Yes No

3. Has anyone **O**bserved you stop breathing during your sleep?

   Yes No

4. Do you have or are you being treated for high blood **P**ressure?

   Yes No

5. **B**ody Mass Index (BMI) more than 35 (use the formula to calculate your BMI)?

   Yes No

   BMI Formula: (your weight in pounds X 703)
   BMI = (your height in inches X your height in inches)

6. **A**ge over 50 yr old?

   Yes No

7. **N**eck circumference greater than 40 cm?

   Yes No

8. **G**ender male?

   Yes No

Scoring: Answering "yes" to three of more of the 8 questions indicates that you are High Risk for OSA. Answering "yes" to less than three questions indicates that you are Low Risk for OSA. If you scored in the High Risk for OSA category, a sleep study or an evaluation by a sleep specialist may be warranted.