STOP BANG QUESTIONNAIRE

S – Snoring	Have you been told that you snore?	Yes	No
T – Tired	Do you often feel tired, fatigued or sleepy during the day?	Yes	No
O – Observed	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	Yes	No
P – Pressure	Do you have high blood pressure or are you on medications to control high blood pressure?	Yes	No
B – BMI	Is your body mass index greater than 28 kg?	Yes	No
A – Age	Are you 50 years old?	Yes	No
N – Neck	Is your neck greater than 17 inches (males) or 16 inches (females)?	Yes	No
G – Gender	Are you a male?	Yes	No

Please answer yes or no to the following questions, and use the BMI chart to record your Body Mass Index.
This is a screening tool to assess your risk potential for sleep apnea.

If you answer **yes to less than 2** of these questions you are at a low risk for sleep apnea
If you answer **yes** to **3 or 4** of these questions you are at an intermediate risk for sleep apnea.
If you answer **yes** to **5 or more** of these questions you are at a high risk for sleep apnea