The STOP-BANG Questionnaire

A Screening Tool for Individuals for Obstructive Sleep Apnea (OSA)

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

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

3. Has anyone observed you stop breathing during your sleep? □ Yes □ No

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

5. Body Mass Index (BMI) more than 35 (use the formula to calculate your BMI)? □ Yes □ No

\[
\text{BMI Formula: } \frac{(\text{your weight in pounds} \times 703)}{\text{(your height in inches} \times \text{your height in inches})}
\]

6. Age over 50 yr old? □ Yes □ No

7. Neck circumference greater than 40 cm (16 inches)? □ Yes □ No

8. Gender male? □ Yes □ No

SCORING:

- Answering “yes” to three or more of the eight questions indicates that you are at 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 physician may be warranted.

For more information, questions or concerns call an Atlantic Health Sleep Center (listed above) and ask to speak to a sleep professional.