STOP BANG Questionnaire

Please answer yes or no to the following questions. This is a screening tool to assess the risk potential for sleep apnea.

S - Snoring - have you been told that you snore? Y / N

T - Tired - Do you often feel tired, fatigued, or sleepy during daytime? Y / N

O - Observed - Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep? Y / N

P - Pressure - Do you have high blood pressure or are you on medication to control high blood pressure? Y / N

B - BMI - Is your body mass index greater than 28? Y / N

A - Age - Are you over 50 years old? Y / N

N - Neck Circumference - Are you a male with a neck circumference greater than 17 inches? Or a female with a neck circumference greater 16 inches? Y / N

G - Gender - Are you a male? Y / N

If you answer yes to 3 or more of these questions you are at a high risk for sleep apnea. Please call our office and we can schedule a no risk consultation today!