GRUNWALD
FAMILY DENTISTRY

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Name:_____Date:_____

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

Please circle yes or no to each question.

STOP

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

BANG

5. **B**MI more than 35? Yes No
6. **A**GE over 50 years old? Yes No
7. **N**ECK circumference > 16 inches (40cm)? Yes No
8. **G**ENDER: Male? Yes No

TOTAL SCORE

High risk of OSA: Yes 5 - 8

Intermediate risk of OSA: Yes 3 - 4

Low risk of OSA: Yes 0 - 2