STOP-Bang Questionnaire

Please answer the following questions below to determine if you may be at risk:

**YES**  **NO**

- S  
  Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?

- T  
  Do you often feel **Tired, Fatigued**, or **Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?

- O  
  Has anyone **Observed you Stop Breathing** or **Choking/Gasping** during your sleep?

- P  
  Do you have or are you being treated for **High Blood Pressure**?

- B  
  Body Mass Index more than 35 kg/m$^2$?

- A  
  Age older than 50?

- N  
  Neck size large? (Measured around Adams apple)

- G  
  Gender = Male?

**For general population**

**OSA - Low Risk**: Yes to 0 - 2 questions

**OSA - Intermediate Risk**: Yes to 3 - 4 questions

**OSA - High Risk**: Yes to 5 - 8 questions

- or Yes to 2 or more of 4 STOP questions + male gender
- or Yes to 2 or more of 4 STOP questions + BMI > 35kg/m$^2$
- or Yes to 2 or more of 4 STOP questions + neck circumference 16 inches / 40cm