Screening for Obstructive Sleep Apnea  
STOP BANG Questionnaire

Patient Name: __________________________ Date of Birth: __________________________

I have already been diagnosed with sleep apnea.  
(If yes, you do not need to complete the rest of this form.)

YES □ NO □

1. Snoring: Do you snore loudly (loud enough to be heard through closed doors)?

YES □ NO □

2. Tired: Do you often feel tired, fatigued, or sleepy during daytime?

YES □ NO □

3. Observed: Has anyone observed you stop breathing during your sleep?

YES □ NO □

4. Blood Pressure: Do you have or are you being treated for high blood pressure?

YES □ NO □

5. BMI: BMI more than 35 kg/m²?

YES □ NO □

6. Age: Age over 50 yr old?

YES □ NO □

7. Neck circumference: Neck circumference > 40 cm?

YES □ NO □

8. Gender: Male?

YES □ NO □

High risk of Obstructive Sleep Apnea: Yes to 5-8 questions 
Intermediate risk of Obstructive Sleep Apnea: Yes to 3-4 questions 
Low risk of Obstructive Sleep Apnea: Yes to 0-2 questions 