Stop-Bang Questionnaire

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** Mas Index (BMI) more than 35 (use the formula to calculate your BMI)?
   _____Yes _____No
   BMI Formula $\frac{\text{(your weight in pounds X 703)}}{\text{(your height in inches X your height in inches)}}$

6. **Age** over 50 yr old?
   _____Yes _____No

7. **Neck** circumference greater than 40 cm?
   _____Yes _____No

8. **Gender** Male?
   _____Yes _____No

Scoring:
Answering **"yes"** to **three or more** of the 8 questions indicated that you are at **High Risk for OSA**. Answering **"yes"** to **less than three** questions indicated that you are at Low Risk for OSA. If you scored in the **High Risk for OSA** category, a **sleep study** or an **evaluation** by a **sleep specialist** may be warranted.