

Screening Tool for Obstructive Sleep Apnea

STOP-BANG Questionnaire

1 SNORING

Do you *snore* loudly (louder than talking or loud enough to be heard through closed doors)?

YES NO

2 TIRED

Do you often feel *tired*, fatigued or sleepy during the 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 35kg/m²?

YES NO

6 AGE

Age over 50 years old?

YES NO

7 NECK CIRCUMFERENCE

Neck circumference greater than 40cm / 16”?

YES NO

8 GENDER

Gender - Male?

YES NO

Yes to 0 - 2 questions: OSA risk is LOW

Yes to 3 - 4 questions: OSA risk is INTERMEDIATE

Yes to 5-8 questions: OSA risk is HIGH
