STOP-BANG Sleep Apnea Questionnaire

Phone/Text #	**Email:**
Height: ___Feet_____Inches. [Height in Total Inches_____] [12xfeet+inches=Total Inches]	Weight: _____lbs. Age: _____ Weight: _____ in Kgs[1kg=2.20462 lbs.]
Collar size of shirt (Circle Applicable Size): Small Medium. Large XL **Other: [ ]**	Neck circumference* _____ inches/cm (circle) (1 inch=2.54cm)

STOP	**Please circle the applicable option.**	
Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel **TIRED**, fatigued, or sleepy during daytime?	Yes	No
Has anyone **OBSERVED** you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for High **Blood PRESSURE?**	Yes	No
BANG (to be review and filled office doctor)	**For OFFICE USE**	
BMI [lbs./ $(in)^2$] x 703=_____Kg/M^2--Is this more than 35kg/ M^2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE (by Office Doctor)	

Example for BMI Calculation: Height 70 inches and Weight 160 lb.
BMI = [160 / $(70)^2$] x 703 = 160/4900 x 703 = 22.9 (example)

Scoring Criteria: For general population:

Low risk of OSA: Yes to 0-2 questions
Intermediate risk of OSA: Yes to 3-4 questions
High risk of OSA: 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 > 35 kg/m2
or yes to 2 or more of 4 STOP questions + neck circumference (17"/43cm in male, 16"/41cm in female)