STOP-BANG Sleep Apnea Questionnaire

Name:____

Date:____

Height:_________ **Weight:**_________ **Age:**______ **Gender:**_________

Snoring – Do you snore loudly?	YES	NO
Tiredness – Do you often feel tired, fatigued or sleepy during the day?	YES	NO
Observation – Has anyone observed you stop breathing during your sleep?	YES	NO
Pressure – Do you have or are you being treated for high blood pressure?	YES	NO
BMI – Is your BMI	YES	NO
Age – Are you over the age of 50 years old?	YES	NO
Neck – Is your neck circumference greater than 16 inches (40cm)?	YES	NO
Gender – Are you male?	YES	NO