STOP BANG Questionnaire

Are you at risk of obstructive sleep apnea? Use this questionnaire to determine whether you should seek follow-up with a qualified sleep specialist.

Height _____ inches/cm Weight ___ lb/kg Age ______ Male/Female BMI ____

Collar size of shirt: S, M, L, XL, or _____ inches/cm

1. ***S***noring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
   Yes No

2. ***T***ired: Do you often feel tired, fatigued, or sleepy during daytime?
   Yes No

3. ***O***bserved: Has anyone observed you stop breathing during your sleep?
   Yes No

4. Blood ***P***ressure: Do you have or are you being treated for high blood pressure?
   Yes No

5. ***B***MI: Is your BMI more than 35 kg/m^2?
   Yes No

6. ***A***ge: Is your age over 50 yr old?
   Yes No

7. ***N***eck circumference: Is your neck circumference greater than 40 cm?
   Yes No

8. ***G***ender: Is your gender male?
   Yes No

High risk of OSA: answering yes to three or more items
Low risk of OSA: answering yes to less than three items

Adapted from:
STOP Questionnaire
A Tool to Screen Patients for Obstructive Sleep Apnea
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