STOP-BANG QUESTIONNAIRE

PATIENT RESPONSES:

1. Do you snore loudly (someone can hear you in the other room)?.....Yes No

2. Do you often feel tired, fatigued, or sleepy during the daytime?.....Yes No

3. Has anyone observed you stop breathing during sleep?.....Yes No

4. Do you have hypertension/high blood pressure?.....Yes No

---------- Patient can STOP here!

OBJECTIVE INFORMATION:

5. BMI greater than 35 kg/m2?.....Yes No

6. Age greater than 50 years? .....Yes No

7. Neck Circumference > 40 cm? .....Yes No

8. Is the patient male? .....Yes No

FINAL ASSESSMENT

Number of YES Responses? ___ (0-8)

0-2 -> LOW RISK -> DEFER Sleep Study

3+ -> HIGH RISK -> REFERRAL Sleep Study