

STOP BANG QUESTIONNAIRE

(PLEASE CIRCLE)

Snoring – Do you snore loudly (loud enough to be heard through closed doors or your bed partner elbow you for snoring) at night? **Y or N**

Tired – Do you often feel tired, fatigued, or sleepy during the daytime (such as falling asleep during driving)? **Y or N**

Observed – Has anyone observed you stop breathing or choking / gasping during your sleep? **Y or N**

Pressure – Do you have or have you been treated for High Blood Pressure? **Y or N**

Body Mass Index – More than 10% over ideal range. **Y or N**

Age – Older than 50? **Y or N**

Neck size – (Measure around Adams apple) – Male: Is your shirt collar 17” or larger?
Female: Is your shirt collar 16” or larger? **Y or N**

Gender = Male? **Y or N**

After you have completed the STOP-BANG questionnaire, please return it to the front desk for a quick risk assessment of your sleep health.