STOP-BANG Questionnaire

Name of Patient: _____ Date of Birth: _____

Today's Date: _____

1. S – Snoring Yes No

Do you snore loudly?
(loud enough to be heard through closed doors, or your bed partner elbows you at night?

2. T – Tired Yes No

Do you often feel tired, fatigued or sleepy during the day time?
(such as falling asleep during driving or while talking to someone?)

3. O – Observed Yes No

Has anyone observed you stop breathing or choking gasping during sleep?

4. P – Pressure Yes No

Do you have, or are you being treated for, high blood pressure?

5. B – Body Mass > 35g/m^2 Yes No

Height =
Weight =

6. A – Age older 50? Yes No

7. N – Neck Size Yes No

Is your shirt collar 16 inches / 40cm or larger?

8. G – Gender is Male Yes No

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