STOP-BANG QUESTIONNAIRE FOR OBSTRUCTIVE SLEEP APNEA

Instructions: Please answer **Yes** or **No** to the following questions.

Questionnaire

- **S (Snoring):** Do you **Snore Loudly**? (Loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night?)
  - [ ] Yes [ ] No
- **T (Tired):** Do you often feel **Tired, Fatigued, or Sleepy during the daytime** (such as falling asleep during driving or talking to someone)?
  - [ ] Yes [ ] No
- **O (Observed):** Has anyone **Observed** you **stop breathing** or **choking/gasping** during your sleep?
  - [ ] Yes [ ] No
- **P (Pressure):** Do you have or are you being treated for **High blood pressure**?
  - [ ] Yes [ ] No
- **B (BMI):** Is your **Body Mass Index (BMI) more than 35 kg/m²**?
  - [ ] Yes [ ] No
- **A (Age):** Are you **Older than 50 years old**?
  - [ ] Yes [ ] No
- **N (Neck circumference: Measured around Adam's apple):** Is your neck shirt size 16 inches (40 cm) or larger?
  - [ ] Yes [ ] No
- **G (Gender):** Are you biologically male?
  - [ ] Yes [ ] No

Total Score: (Total "Yes" Answers): ____

For general population	
OSA-Low Risk	Yes to 0-2 questions
OSA- Intermediate Risk	Yes to 3-4 questions
OSA-High Risk	Yes to 5-8 questions
	Or Yes to 2 or more of 4 STOP questions + male gender
	Or Yes to 2 or more of 4 STOP questions + BMI more than 35 kg/m²?
	Or Yes to 2 or more of 4 STOP questions + neck circumference 16 inches / 40 cm

Source: Modified from Chung F et al. Anesthesiology 2008;108: 812-821, Chung F at al Br J Anaesth 2012; 108: 768-775, Chung F at al J Clin Sleep Med Sept 2014.