SMALLWOOD
DENTAL SOLUTIONS

STOP-BANG Sleep Apnea Questionnaire

Name: _____ Age: _____

Height: _____ Weight: _____ Gender: _____

Have you been diagnosed with Sleep Apnea? Yes | No

If yes, are you currently using a CPAP? Yes | No

If yes to both of these questions, stop here.

STOP		
Do you ***S**NORE* loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel ***T**IRED*, fatigued, or sleepy during daytime?	Yes	No
Has anyone ***O**BSERVED* you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood ***P**ressure*?	Yes	No
BANG		
***B**MI* more than 28?	Yes	No
***A**GE* over 50 years old?	Yes	No
***N**ECK* circumference greater than 17 inches if male, and 16 inches if female?	Yes	No
***G**ENDER*: Male?	Yes	No

TOTAL SCORE	

5-8: High risk of OSA
3-4: Intermediate risk of OSA

0-2: Low risk of OSA

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