NAME:_____ DOB:_____ TODAYS DATE_____

STOP-Bang Screening Tool for Obstructive Sleep Apnea (OSA)

STOP-BANG SCORING MODEL

Please answer each question by circling yes or no

1. Snoring:
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
Yes / No

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

3. Observed:
Has anyone observed you stop breathing during your sleep?
Yes / No

4. Blood Pressure:
Do you have or are you being treated for high blood pressure?
Yes / No

5. BMI:
BMI more than 35 kg/m2
Yes / No

6. Age:
Age over 50 years old?
Yes / No

7. Neck circumference:
Neck circumference greater than 40 cm?
Yes / No

8. Gender:
Male
Yes / No

High risk of OSA: *answering yes to three or more items*

Low risk of OSA: *answering yes to less than three items.*