CENTRAL JERSEY DENTAL SLEEP MEDICINE

www.SnoreDentist.com
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STOP-BANG Screening Questionnaire for Sleep Apnea

Is it possible that you have Obstructive Sleep Apnea (OSA)?

Please answer the following questions below to determine if you might be at risk.

Yes ○ No ○ **S**noring? **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**ired ? Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling sleep during driving or talking to someone)?

Yes ○ No ○ **O**bserved? Has anyone **observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?

Yes ○ No ○ **P**ressure? Do you have or are being treated for **High Blood Pressure**?

Yes ○ No ○ **B**ody Mass Index more than 35 kg/m^2? (Overweight)

Yes ○ No ○ **A**ge older than 50?

Yes ○ No ○ **N**eck size large? (Measured around Adams apple)
For male, is your shirt collar 17 inches or larger?
For female, is your shirt collar 16 inches or larger?

Yes ○ No ○ **G**ender = Male?

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 > 35kg/m^2
or Yes to 2 or more of 4 STOP questions + neck circumference 17 inches in male or 16 inches in female