STOP BANG Screening Questionnaire

Name : _____

d.o.b. : _____ Height : _____ Weight _____

Date : _____

Please answer the following questions below to determine if you might be at risk of Obstructive Sleep Apnoea (OSA)

		YES	NO
S	**Snoring ?** Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?		
T	**Tired ?** Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?		
O	**Observed ?** Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep ?		
P	**Pressure ?** Do you have or are being treated for **High Blood Pressure** ?		
B	**Body Mass Index more than 35 kg/m^2?**		
A	**Age older than 50 ?**		
N	**Neck size large ? (Measured around Adams apple)** For male, is your shirt collar 17 inches / 43cm or larger? For female, is your shirt collar 16 inches / 41cm or larger?		
G	**Gender = 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 / 43cm in male or 16 inches / 41cm in female

This tool is adapted from the STOP BANG Questionnaire. A Tool to Screen Patients for Obstructive Sleep Apnea. Chung F, Yegneswaran B, Liao P, Chung SA, Vairavanathan S, Islam S, Khajehdenhi A and Shapiro C. *Anesthesiology* 2008;108:812-21.