# STOP-BANG QUESTIONNAIRE

**A tool to screen for obstructive sleep apnea, stop-bang scoring model**

**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**

Is your body mass index more than 35?

_____Yes _____ No

**6. Age**

Are you older than 50?

_____Yes _____ No

**7. Neck Circumference**

Do you have a neck that measures more than 16 inches (women) and more than 17 inches (men)?

_____Yes _____ No

**8. Gender**

Gender = Male?

_____Yes _____ No

| **Low risk of OSA:** | **Intermediate risk of OSA:** | **High risk of OSA:** |
|---|---|---|
| Yes to 0-2 questions | Yes to 3-4 questions | Yes to 5-8 questions |

*Improving your life one night at a time!*

Email your completed form to sleep@eastcoastsleepclinic.com

Date: _____

Referred by: _____

Patient Name: _____

Date of Birth: _____ Medicare Number: _____
DD/MM/YY

Phone Numbers: _____

Home: _____Work: _____ Cell: _____

Reason for Referral:

_____

**Home Sleep Studies, CPAP Trials and CPAP check-ups are FREE of charge**

☐ I am referring this patient for a sleep study

_____

☐ I am referring this patient for a sleep study. If the Physician Interpreted study indicates Obstructive Sleep Apnea, please Proceed with CPAP therapy/humidifier and mask.

_____

☐ I am referring this patient for a CPAP Trial

_____

Signature: _____

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