

HEALTH ANALYSIS

STOP-BANG Questionnaire

A Tool to Screen Patients for Obstructive Sleep Apnea (OSA)

Height _____ inches/cm

Weight _____ lb/kg

Age _____

Male / Female

BMI _____

Collar size of shirt: S M L XL or _____ inches/cm

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 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 BMI more than 35 kg/m²? **Yes** **No**

6. Age
Are you over 50 years old? **Yes** **No**

7. Neck Circumference
Is your neck circumference greater than 40 cm? **Yes** **No**

8. Gender
Are you male? **Yes** **No**

3 or More “Yes” responses = High risk of OSA

3 or Less “Yes” responses = Low risk of OSA

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