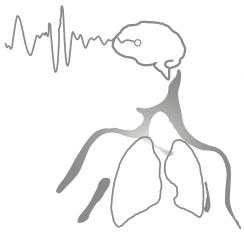

CLINIQUE SOMNOMED

Name:_____

Date:_____

STOP-BANG Sleep apnea questionnaire

		Select	
		Yes	No
S	Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	○	○
T	Do you often feel TIRED, fatigued, or sleepy during daytime?	○	○
O	Has anyone OBSERVED you stop breathing during your sleep?	○	○
P	Do you have or are you being treated for high blood PRESSURE?	○	○
B	Body Mass Index (BMI) more than 35 kg/m^2?	○	○
A	AGE over 50 years old?	○	○
N	Is your NECK size larger than 43cm if male or 41cm if female?	○	○
G	Are you MALE?	○	○

High risk of OSA: 5 - 8 Yes
Intermediate risk of OSA: 3 - 4 Yes
Low risk of OSA: 0 - 2 Yes

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SUBMIT