Ottesen
FAMILY DENTISTRY

STOP-BANG Sleep Apnea Questionnaire

Name:_____ Today's Date:_____

Birth Date:_____ Age:_____ Height:_____ Weight:_____ Sex: M / F

STOP	YES	NO
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?		
Do you often feel **T**IRED, fatigued, or sleepy during daytime?		
Has anyone **O**BSERVED you stop breathing during your sleep?		
Do you have or are you being treated for high blood **P**RESSURE?		

BANG	YES	NO
BMI more than 35 kg/m^2?		
AGE over 50 years old?		
NECK circumference > 16 inches (40 cm)?		
GENDER: Male?		

TOTAL SCORE		

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

Chung F et al Anesthesiology 2008 and BJA 2012