# STOP-BANG Questionnaire

ST. JOSEPH HOSPITAL
A Member of Covenant Health

**Snoring:** Do you snore loudly (loud enough to be heard through closed doors)? YES NO

**Tired:** Do you often feel tired, fatigued, or sleepy during the daytime? YES NO

**Observed:** Has anyone observed you stop breathing during your sleep? YES NO

**Blood Pressure:** Do you have high blood pressure/currently being treated for high blood pressure? YES NO

**BMI:** Is your BMI more than 35kg/$m^2$? YES NO

**Age:** Are you older than 50 years old? YES NO

**Neck Circumference:** Is your neck circumference greater than or equal to 16 in. (female) or 17 in. (male)? YES NO

**Gender:** Male? YES NO

***HIGH RISK OF OSA:*** YES TO 3 OR MORE QUESTIONS

***LOW RISK OF OSA:*** YES TO LESS THAN 3 QUESTIONS

**CONTACT YOUR PRIMARY CARE PROVIDER**