Dr Peter Friedland
Adult & Paediatric Ear, Nose and Throat

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STOP-BANG Sleep Apnoea Questionnaire

Name: ______________________________ Date: ______________

Age: ______________ Height: ______________ Weight: ______________ ☐ Male ☐ Female

STOP

Do you **SNORE** (louder than talking or loud enough to be heard through closed doors)? ☐ Yes ☐ No

Do you often feel **TIRED**, fatigued or sleepy during daytime? ☐ Yes ☐ No

Has anyone **OBSERVED** you stop breathing during your sleep? ☐ Yes ☐ No

Do you have or are you being treated for high blood **PRESSURE**? ☐ Yes ☐ No

BANG

BMI: Do you have a BMI greater than 35kg/m2? ☐ Yes ☐ No

AGE: Are you over 50 years old? ☐ Yes ☐ No

NECK: Is your neck circumference larger than 40cm? ☐ Yes ☐ No

GENDER: Are you a male? ☐ Yes ☐ No

TOTAL: ______________

Number of Yes Responses

High Risk of OSA: **5 –8** Yes Responses

Intermediate risk of OSA: **3 –4** Yes Responses

Low risk of OSA: **0 –2** Yes Responses

Compiled by Chung F et al Anesthesiology 2008 and BJA 2012