SPIRA

Dental | Sleep | Therapy

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STOP-BANG Sleep Questionnaire

Name: _____ **Date:** _____

Please answer the following questions by checking "yes" or "no" for each one?

Do you snore loudly?	Yes	No
Do you often feel tired, fatigued, or sleepy during the daytime?	Yes	No
Has anyone observed that you stop breathing, or choke or gasp during your sleep?	Yes	No
Do you have or are you being treated for high blood pressure?	Yes	No
Is your body mass index more than 35kg per m^2?	Yes	No
Are you older than 50 years?	Yes	No
Is your neck circumference greater than 15.75 inches (40cm)?	Yes	No
Are you male?	Yes	No

Total Yes: _____

Scoring interpretation: 0-2 is low risk; 3-4 is intermediate risk; ≥5 is high risk