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S.T.O.P. - B.A.N.G. QUESTIONNAIRE
For the Assessment of Obstructive Sleep Apnea Risk:

Please answer the following eight questions with a Yes or No response.	
1. **S**noring: Do you snore loudly (i.e. louder than talking OR loud enough to be heard through closed doors)?	Y / N
2. **T**iredness: Do you often feel tired, sleepy, or fatigued during the day?	Y / N
3. **O**bserved Apnea: Have you ever been told that you stop breathing during your sleep?	Y / N
4. **P**ressure: Do you have or are you being treated for hypertension?	Y / N
5. **B**MI: Do you weigh more for your height than shown in the corresponding chart on the right (i.e. BMI > 35)?	Y / N
6. **A**ge: Are you over 50 years old?	Y / N
7. **N**eck Size: Is your neck size greater than 15 ¾" or 40 cm?	Y / N
8. **G**ender: Are you a male?	Y / N
SCORE: Total number of "Yes" answers?	____

HEIGHT	WEIGHT
4'10	167
4'11	173
5'0	179
5'1	185
5'2	191
5'3	197
5'4	204
5'5	210
5'6	216
5'7	223
5'8	230
5'9	237
5'10	243
5'11	250
6'0	258
6'1	265
6'2	272
6'3	279
6'4	287
6'5	295

☐ **High Risk of OSA: 3 or more "Yes" Answers**
Please take this form to your physician to discuss your sleep related concerns.

☐ **Low Risk of OSA: 0-2 "Yes" Answers**
Talk with your physician if you have other sleep complaints.

**** This screening questionnaire is not a substitute for professional medical advice, and should not be used to diagnose or treat a health problem. Please consult with your primary care physician or healthcare provider if you have any questions or concerns.*

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