ISMC
Illawarra Sleep Medicine Centre

STOP BANG QUESTIONNAIRE

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PATIENT INFORMATION

NAME: _____

HEIGHT: _____ WEIGHT: _____

GENDER: _____ AGE: _____

STOP

DO YOU SNORE LOUDLY (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 MORE THAN 35KG/M^2	☐ YES	☐ NO
AGE OVER 50 YEARS OLD?	☐ YES	☐ NO
NECK CIRCUMFERENCE OVER 16 INCHES (40CM)?	☐ YES	☐ NO
GENDER: MALE?	☐ YES	☐ NO

TOTAL SCORE:	

LOW RISK OF OSA: YES 0 - 2 INTERMEDIATE RISK OF OSA: YES 3 - 4 HIGH RISK OF OSA: YES 5 - 8