**STOP-BANG QUESTIONNAIRE**

**S**NORING - Do you snore loudly (loud enough to be heard through closed doors Y/N

or your bed-partner elbow you for snoring at night?

**T**IRED – Do you often feel Tired , Fatigued, or Sleepy during the daytime (such as Y/N

 almost falling asleep during driving)?

**O**BSERVED – Has anyone Observed you Stop Breathing or Choking / Gasping during Y/N

your sleep?

**P**RESSURE – Do you have or are you being treated for High Blood Pressure Y/N

**B**ODY MASS INDEX (BMI) – More than 10% over ideal range? Y/N

**A**GE – Older than 50? Y/N

**N**ECK SIZE – (Measure around Adams Apple)

Male shirt collar 17” or greater/ Female is your shirt 16” or larger? Y/N

**G**ENDER – Male

 Y/N

After you have completed the **STOP – BANG** questionnaire, please return it to the front desk for a quick assessment of your sleep health.