QUESTIONNAIRE

## STOP-BANG QUESTIONNAIRE

**S**NORING - Do you snore loudly (loud enough to be heard through closed doors or your bed-partner elbow you for snoring at night? Y/N

**T**IRED – Do you often feel Tired , Fatigued, or Sleepy during the daytime (such as almost falling asleep during driving)? Y/N

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

**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.