Sarah Bush Lincoln

SLEEP DISORDERS CENTER
1005 Health Center Dr, Mattoon, IL 61938, 217-238-4908

STOP BANG Questionnaire: Sleep Apnea Screening Tool

Name:_____ DOB:_____ Date:_____

Height _____ inches/cm Weight _____ lb/kg BMI _____

1. Do you **snore?**
   Yes or No

2. Do you often feel **tired**, fatigued, or sleepy during daytime?
   Yes or No

3. Has anyone **observed** you stop breathing during your sleep?
   Yes or No

4. Do you have or are you being treated for high blood **pressure**?
   Yes or No

5. **BMI** more than 35 kg/m2?
   Yes or No

6. **Age** _____ Are you over 50 years old?
   Yes or No

7. **Neck** circumference _____ cm. Is it greater than 40cm?
   Yes or No

8. **Gender** = male?
   Yes or No

High risk of OSA: answering yes to three or more items
Low risk of OSA: answering yes to less than three items

If patient has a high risk of OSA please refer patient for a baseline sleep study (All night polysomnogram) by contacting Central Scheduling to schedule appointment 217-258-2588 or you may contact the Sleep Disorders Center at 217-238-4908 for additional information.

Adapted from: STOP Questionnaire: *A Tool to Screen Patients for Obstructive Sleep Apnea*
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