STOP - BANG

PATIENT SCREENING FOR OBSTRUCTIVE SLEEP APNEA

Please answer the following questions to find out if you are at risk for Obstructive Sleep Apnea.

STOP:

S (SNORE)	Have you been told that you snore?	YES / NO
T (TIRED)	Are you often tired during the day?	YES / NO
O (OBSTRUCTION)	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	YES / NO
P (PRESSURE)	Do you have high blood pressure or on medication to control high blood pressure?	YES / NO

BANG:

B (BMI)	Is your body mass index greater than 35? *(See BMI chart, included on page 3)*	YES / NO
A (AGE)	Are you 50 years old or older?	YES / NO
N (NECK)	MEN: Is your neck circumference (collar size) greater than 17 inches?	YES / NO
	WOMEN: Is your neck circumference greater than 16 inches?	YES / NO
G (GENDER)	Are you male?	YES / NO

PATIENT NAME: _____ DATE OF BIRTH: _____
(Please print)

PATIENT SIGNATURE: _____ Today's Date: _____