STOP-BANG: Sleep Apnea Questionnaire

(801) 783-1082

Name ___________________________________
Height ___________ Weight _________ Age __________
Male / Female ___________

S.T.O.P.

1. Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)? Yes/No
2. Do you often feel TIRED, fatigued, or sleepy during daytime? Yes No
3. Has anyone OBSERVED you stop breathing during your sleep? Yes No
4. Do you have or are you being treated for high blood PRESSURE? Yes No

B.A.N.G.

5. BMI more than 35kg/m2? Yes No
6. AGE over 50 years old? Yes No
7. NECK circumference > 16 inches (40cm)? Yes No
8. GENDER: Male? Yes No

TOTAL SCORE
High risk of OSA: Yes 5 - 8
Intermediate risk of OSA: Yes 3 - 4
Low risk of OSA: Yes 0 - 2

Have you had a sleep analysis lately? If you haven't ***within the past year***, please add up your up your totals, of this test, take a screenshot and email the results with your name and best contact phone number to: reservation@pinecrestdds.com. Then we'll provide you with a complementary analysis to discuss if further evaluation is right for you!