TEXAS: PH: 512.255.2727 / FAX TO 512.212.9373
NEW JERSEY: PH: 908.688.6088 / FAX TO 908.688.8115

Name ___________________________________ Height _______ Weight _______

Age ______ Male/Female ______ Tel/Mobile# ______________________________

Physician Name: ____

Physician Tel: _______________________________ City/State: _________________

STOP-BANG Sleep Apnea Questionnaire

STOP	YES	NO
Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed doors)?		
Do you often feel **TIRED**, fatigued, or sleepy during daytime?		
Has anyone **OBSERVED** you stop breathing during your sleep?		
Do you have or are you being treated for high blood **PRESSURE**?		

BANG	YES	NO
BMI >=25 (*see below formula) or Overweight?		
AGE over 50 years old?		
NECK Circumference > 17” male or 16” female		
GENDER: Male?		

TOTAL SCORE (Count “YES”s)		

High Risk of OSA: Total Score of Yeses >= 3

* **Formula for BMI: [Weight in pounds/(height (inches)* height)] * 703**