PRESTIGE
Family Medicine

Patient Name:_____ Date:_____

STOP-BANG Sleep Apnea Questionnaire

S (snore)	Do you SNORE?	Yes	No
T (tired)	Do you often feel TIRED or sleepy during the daytime?	Yes	No
O (observed)	Has anyone OBSERVED you stop breathing during your sleep (even	Yes	No
P (pressure)	Do you have or are you being treated for high blood PRESSURE?	Yes	No

B (bmi)	Is your Body Mass Index (BMI) more than 35?	Yes	No
A (age)	Is your AGE over 50 years old?	Yes	No
N (neck)	Is your NECK circumference 16 inches or greater?	Yes	No
G (gender)	Is your GENDER male?	Yes	No

The more Yes's you have the more likely you are to have obstructive sleep apnea. Speak with your healthcare provider about your results.