Sleep Easy Nevada

The STOP-Bang Questionnaire

Is it possible that you have Obstructive Sleep Apnea?
Please answer the following **HIGHLIGHTED** questions to determine if you are at risk.

Snoring ?	Do you Snore Loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?	YES	NO
Tired?	Do you often feel Tired, Fatigued, or Sleepy during the daytime (such as falling asleep during driving or talking to someone)?	YES	NO
Observed?	Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep?	YES	NO
Pressure?	Do you have or are being treated for High Blood Pressure?	YES	NO
BMI	Body Mass Index more than 35 kg/m2?	YES	NO
Age	Age older than 50 ?	YES	NO
Neck size	Neck size / shirt collar 16 inches / 40cm or larger? (Measured around Adams apple)	YES	NO
Gender	Gender = Male ?	YES	NO

Date_____

Name:_____ Male Female DOB_____ Your Age_____

Best Contact #_____ Best Email:_____

Do You Have Medical Ins? YES. NO. Name of Ins if Yes:_____

Have you been told you have Sleep Apnea? YES NO. Do you currently use a CPAP Device? YES. NO

Have you ever had a Sleep Apnea Test? YES. NO

Screening Data Collected by_____ Location_____

Height_____ Weight_____ Shirt Collar Size_____ BMI_____**SB SCORE**_____

YES TO 0-2 QUESTIONS LOW RISK YES TO 3-4 QUESTIONS INTERMEDIATE RISK YES TO 5 PLUS HIGH RISK

HIGH RISK
YES TO 2-4 OR MORE PLUS MALE OR. YES TO 2 -4 MORE PLUS BMI ABOVE 35. OR YES TO 2-4 OR MORE PLUS NECK SIZE >16 IN

References: