

STOP-Bang Questionnaire

1. **Snoring:** Do you snore loudly (loud enough to be heard through closed doors)?

Yes No

2. **Tired:** Do you often feel tired, fatigued, or sleepy during daytime?

Yes No

3. **Observed:** Has anyone observed you stop breathing during your sleep?

Yes No

4. **Blood Pressure:** Do you have or are you being treated for high blood pressure?

Yes No

5. **BMI:** BMI more than 35 kg/m²?

Yes No

6. **Age:** Age over 50 years old?

Yes No

7. **Neck circumference:** Neck circumference greater than 40 cm?

Yes No

8. **Gender:** Male?

Yes No

High risk of OSA: Yes to 3 or more questions

Low risk of OSA: Yes to less than 3 questions

Chung F et al. *Anesthesiology* 2008;108:812-21.