SLEEPTEST.COM

STOP-BANG Questionnaire

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

5. **Body** Mass Index (BMI) more than 35 (use the formula to calculate your BMI)?

   ☐ Yes ☐ No

   BMI Formula:

$$BMI = \frac{\textit{(your weight in pounds X 703)}}{\textit{(your height in inches X your height in inches)}}$$

6. **Age** over 50 yr old?

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

8. **Gender** male?

   ☐ Yes ☐ No