

Stop Bang Screening Tool¹

- | | | |
|--------------------------|--------------------------|--|
| Y | N | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you snore loudly? Louder than talking, or to be heard through closed doors? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you often feel tired, fatigued, or sleepy during the daytime? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has anyone observed you stop breathing during your sleep? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have, or are you being treated for high blood pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your BMI greater than 35? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you over 50 years old? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your neck circumference > 41 cm (women) or > 43 cm (men)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you male? |

RISK OF OSA

Low:

Yes to 0-2 questions

Intermediate:

Yes to 3-4 questions

High:

Yes to 5-8 questions

Score

(total number of "Yes" answers)

¹ Chung F et al J Clin. Sleep Med. Sept 2014.
<http://www.stopbang.ca/osa/screening.php>

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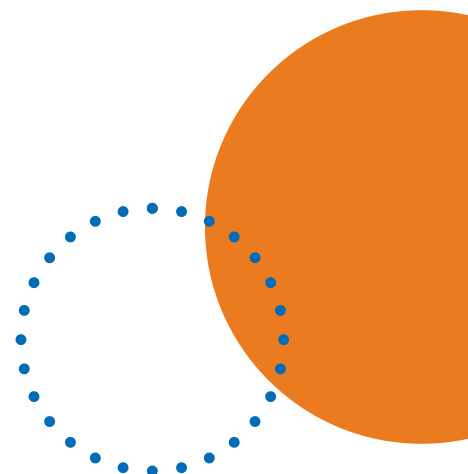
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