



# Stop Bang Screening Tool<sup>1</sup>

- |                          |                          |  |
|--------------------------|--------------------------|--|
| 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)

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

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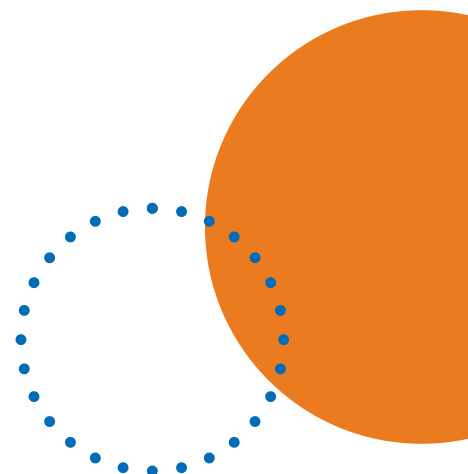
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