



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:

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

6. **Age** over 50 yr old?
 Yes No
 7. **Neck** circumference greater than 40 cm?
 Yes No
 8. **Gender** male?
 Yes No
-