BELLINGHAM BAY DENTAL

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STOP BANG – Screening for Obstructive Sleep Apnea

Name: _____ Phone: _____ Date: _____

Please answer the following questions to find out if you are at risk for sleep apnea:

Snore	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Tired	Do you often feel tired, fatigued, or sleepy during daytime?	Yes	No
Observed	Has anyone observed you stop breathing during your sleep?	Yes	No
Pressure	Do you have or are you being treated for high blood pressure?	Yes	No
BMI	Is your Body Mass Index greater than 35? (See chart on reverse for calculation)	Yes	No
Age	Are you over 50 years old?	Yes	No
Neck	Is your neck circumference greater than 16 inches?	Yes	No
Gender	Are you male?	Yes	No

If you answered yes to **three or more** items, you have a **high** risk of having Obstructive Sleep Apnea.

If you answered yes to **fewer than three** items, your risk of having Obstructive Sleep Apnea is considered to be **low**.