

STOP BANG

Screening for Obstructive Sleep Apnea

Answer the following questions to find out if you are at risk for Obstructive Sleep Apnea.

STOP

| | | |
|------------------------|--|----------|
| S (snore) | Have you been told that you snore? | Yes / No |
| T (tired) | Are you often tired during the day? | Yes / No |
| O (obstruction) | Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep? | Yes / No |
| P (pressure) | Do you have high blood pressure or are you on medication to control high blood pressure? | Yes / No |

If you answered yes to two or more questions on the STOP portion, you are at risk for Obstructive Sleep Apnea. It is recommended that you contact your primary care provider to discuss a possible sleep disorder. To find out if you are at a moderate to severe risk of Obstructive Sleep Apnea, complete the BANG questions below.

BANG

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|-------------------|--|----------|
| B (BMI) | Is your body mass index greater than 28? | Yes / No |
| A (age) | Are you 50 years old or older? | Yes / No |
| N (neck) | Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches? | Yes / No |
| G (gender) | Are you a male? | Yes / No |

The more questions you answer yes to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea.

Patient Name: _____ Date: _____