



SLEEP APNEA SCREENING

Patient Name: _____

Have you ever been diagnosed with Sleep Apnea? Yes No

If so, what is your current treatment? CPAP BIPAP Oral Appliance Other: _____

STOPBANG Sleep Apnea Questionnaire:

- 1. Do you **S**nore loudly? (Meaning louder than talking or loud enough to be heard through doors?) Yes No
- 2. Do you often feel **T**ired, fatigued or sleepy during the daytime? Yes No
- 3. Has anyone **O**bserved you stop breathing, choke or gasp during your sleep? Yes No
- 4. Do you have or are you being treated for high blood **P**ressure? Yes No
- 5. Is your **B**ody Mass Index (BMI) more than 35? (We will calculate this for you.) BMI - _____ Yes No
- 6. **A**re you over 50 years old? Yes No
- 7. **N**eck circumference? (We will measure this for you.) Yes No
 - a. Men – Shirt collar over 17 inches (43 cm) Collar Size - _____
 - b. Women – Shirt collar over 16 inches (41 cm) Collar Size - _____
- 8. Male **G**ender? Yes No

How many questions above did you answer "Yes" to? _____

Patient Signature: _____

Date: _____

🎉 Thank you for completing this questionnaire. Your results will be discussed during your visit today. 🎉

Disclaimer: This screening tool is used only to assess your health risk associated with sleep apnea. Sleep apnea has many significant implications, some of which could be fatal if left untreated. As your provider, I am responsible for helping you promote health and well being. This screening tool is one way to do this. This simple and quick questionnaire has been proven to effectively screen for this type of treatable disease.