Stop Bang Sleep Test

Doctor Information

Doctor's GMC Number Or Surgery Stamp

Doctor's Name .....

Doctor's Phone Number .....

Doctor's Address .....

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Doctor's Signature ..... Date .....

Patient Information

Patient's Name ..... Patient's Address .....

Patient's DOB ....

Patient's Phone No ....

The STOP-BANG questionnaire is an easy-to-use screening tool for indicating patient risk to Obstructive Sleep Apnea (OSA)

Please answer all questions	Please tick : YES	NO
SNORING: **Do you snore loudly** (louder than talking or loud enough to be heard through closed doors)?	☐	☐
TIRED: **Do you often feel tired, fatigued or sleepy during daytime?**	☐	☐
OBSERVED: **Has anyone observe you stopping breathing during your sleep?**	☐	☐
BLOOD PRESSURE: **Do you have** (or are you being treated for) **high blood pressure?**	☐	☐
BMI: **Is your BMI more than 35kg/m2?**	☐	☐
AGE: **Are you over 50 years old?**	☐	☐
NECK SIZE: **Is your neck circumference greater than 40cm/15¾"?**	☐	☐
GENDER: **Are you male?**	☐	☐

For every "Yes" answer give yourself a score of one

YOUR TOTAL SCORE ___

Below 3 = low risk.
3 and above = high risk.