ALASKA SLEEP CLINIC
an ALYESKA INTERNATIONAL, INC. company

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STOP BANG Questionnaire

Patient Last Name:_____First Name:_____DOB:_____

1. Snoring: Do you snore loudly (loud enough to be heard through a closed door)? _____ Yes _____No
2. Tired: Do you often feel tired, fatigued, or sleepy during the daytime? _____ Yes _____No
3. Observed: Has anyone observed you stop breathing during your sleep? _____ Yes _____No
4. Blood pressure: Do you have or are you being treated for high blood pressure? _____ Yes _____No
5. BMI: Is your Body Mass Index more than 35 kg/m2? _____ Yes _____No
6. Age: Are you over 50 years of age? _____ Yes _____No
7. Neck circumference: Is your neck circumference greater than 40cm? _____ Yes _____No
8. Gender: _____ Male _____ Female

- Neck circumference is measured by staff.
- High Risk of OSA: Answering yes to three or more questions
- Low Risk of OSA: Answering yes to less than three questions.