STOP-Bang Scoring Model

Patient Name: _____

Health Card Number: _____

Date: _____

Completed by: _____

1. **Snoring** Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	☐ Yes ☐ No
2. **Tired** Do you often feel tired, fatigued, or sleepy during 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 BMI more than 35 kg/m^2?	☐ Yes ☐ No
6. **Age** Is your age over 50 years old?	☐ Yes ☐ No
7. **Neck Circumference** Is your neck circumference greater than 40 cm?	☐ Yes ☐ No
8. **Gender** Is your gender male?	☐ Yes ☐ No
High risk of Sleep Apnea if **YES** answered to **3 or more questions** ☐	
Lower risk of Sleep Apnea if **YES** answered to **less than 3 questions** ☐	

*Source: Anesthesiology 2008; 108: 812-821