



STOP- BANG SCORING MODEL (OSA)

STOP-BANG Questions

1. **S**noring
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
Yes No

- 2) **T**ired
Do you often feel tired, fatigued, or sleepy during the daytime?
Yes No

- 3) **O**bserved breathing pattern
Has anyone observed you stop breathing during your sleep?
Yes No

- 4) **B**lood **P**ressure
Do you have or are you being treated for high blood pressure?
Yes No

- 5) **B**MI - BMI more than 35?
Yes No

- 6) **A**ge -- Age over 50 year old?
Yes No

- 7) **N**eck Circumference – greater than 40 cm? Approx. 15.75 inch's
Yes No

- 8) **G**ender - Gender Male?
Yes No

High risk of OSA: Answering yes to three (3) or more items