Sleep Apnea Questionnaire

Patient Name: _____ DOB: ___ / ___ / ___ □ Male □ Female

Age: _____ Height: _____ Weight: _____

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feed TIRED, fatigued, or sleepy during the daytime?	Yes	No
Has anyone ever OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

- **For Clinical Use Only – DO NOT WRITE BELOW THIS LINE**

TOTAL SCORE		

High risk of OSA: Yes 5-8

Intermediate risk of OSA: Yes 3-4

Low risk of OSA: Yes 0-2