STOP-Bang Scoring Model*

Patient Name: _____ Date: _____

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 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 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 Obstructive Sleep Apnea: answering yes to three or more questions
Low Risk of Obstructive Sleep Apnea: answering yes to less than three questions

*Source: Chung F. et al. STOP Questionnaire. *Anesthesiology* 2008; 108: 812-821

THE SLEEP DISORDERS CLINIC