



The Columbus
SLEEP CENTER
Eric Buck, DDS

STOP-Bang Questionnaire

Please answer the following questions by checking "yes" or "no" for each one

Snoring (Do you snore loudly?)

Tiredness (Do you often feel tired, fatigued, or sleepy during the daytime?)

Observed Apnea (Has anyone observed that you stop breathing, or choke or gasp during your sleep?)

High Blood **P**ressure (Do you have or are you being treated for high blood pressure?)

BMI (Is your body mass index more than 35 kg per m²?)

Age (Are you older than 50 years?)

Neck Circumference (Is your neck circumference greater than 40 cm [15.75 inches]?)

Gender (Are you male?)

Score 1 point for each positive response.

Scoring interpretation: 0 to 2 = low risk, 3 or 4 = intermediate risk, ≥ 5 = high risk.