VACA & KIRBY DENTAL
CARING FOR YOU & YOUR SMILE

STOP-BANG Questionnaire

1. Do you **Snore** loudly (louder than talking or loud enough to be heard through closed doors)?
   ☐ Yes ☐ No
2. Do you often feel **Tired**, fatigued, or sleepy during daytime?
   ☐ Yes ☐ No
3. Has anyone **Observed** you stop breathing during your sleep?
   ☐ Yes ☐ No
4. Do you have or are you being treated for high blood **Pressure**?
   ☐ Yes ☐ No
5. **Body** Mass Index (BMI) more than 35 (use the formula to calculate your BMI)?
   ☐ Yes ☐ No

   BMI Formula:

$$BMI = \frac{\text{(your weight in pounds X 703)}}{\text{(your height in inches X your height in inches)}}$$

6. **Age** over 50 yr old?
   ☐ Yes ☐ No
7. **Neck** circumference greater than 40 cm?
   ☐ Yes ☐ No
8. **Gender** male?
   ☐ Yes ☐ No

Scoring:
Answering **"yes"** to **three or more** of the 8 questions indicates that you are at **High Risk** for OSA. Answering **"yes"** to **less than three** questions indicates that you are at Low Risk for OSA. If you scored in the **High Risk for OSA** category, a **sleep study** or an **evaluation** by a **sleep specialist** may be warranted.