LAURENCE H. STONE, D.D.S.
FAMILY & COSMETIC DENTISTRY
For the smiles of your life.

STOP-BANG Questionnaire

To Assess Risk for an Obstructed Sleep Airway (OSA)

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:

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

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.