St. Claire HealthCare

Sleep Center •
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Obstructive Sleep Apnea Evaluation
STOPBANG Questionnaire

1. Do you ***S***nore loudly (louder than talking or loud enough to be heard through closed doors)?	Y / N
2. Do you often feel ***T***ired, fatigued, or sleepy during the daytime?	Y / N
3. Has anyone ***O***bserved you stop breathing during your sleep?	Y / N
4. Do you have or are you being treated for high blood ***P***ressure?	Y / N
5. ***B***ody Mass Index (BMI) > 35?	Y / N
6. ***A***ge ≥ 50 years-old	Y / N
7. ***N***eck circumference > 15.75 inches?	Y / N
8. Male ***G***ender?	Y / N

Answering *Yes* to 3 or more questions: *High Risk* for Obstructive Sleep Apnea (OSA)

BMI

BMI is >35 if weight is greater than listed for the corresponding height.

Height (in)	Weight (lb)	Height (in)	Weight (lb)
59"	173	68"	230
60"	179	69"	237
61"	185	70"	243
62"	191	71"	250
63"	197	72"	258
64"	204	73"	265
65"	210	74"	272
66"	216	75"	279
67"	223	76"	287