AlfredHealth

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☐ Alfred ☐ Sandringham ☐ Caulfield

STOP-BANG QUESTIONNAIRE FOR OBSTRUCTIVE SLEEP APNOEA

Last name*		First name/s*	
Date of birth*		Sex ☐ Female ☐ Male ☐ Other	

*mandatory fields

Thank you for completing this questionnaire.

(Save questionnaire to your computer to complete electronically)

Date questionnaire completed _____

Snore: do you snore loudly (louder than talking or audible in another room)?	☐ Yes	☐ No
Tired: do you often feel tired, fatigues or sleepy during the daytime?	☐ Yes	☐ No
Observed: has anyone observed you stop breathing during your sleep?	☐ Yes	☐ No
Blood Pressure: do you have, or are you treated for, high blood pressure?	☐ Yes	☐ No
BMI: greater than 35? (ie weight (kg) / height $(m)^2$)	☐ Yes	☐ No
Age: are you aged over 50 years?	☐ Yes	☐ No
Neck Circumference: is your NC greater than 40cm?	☐ Yes	☐ No
Gender: are you male?	☐ Yes	☐ No
TOTAL		

May 2024
Source: Alfred Health Connect

EMR: Assessment_Health Assessment Questionnaire
Reference: Chung et al. Anaesthesiology 2008;108:812-21

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