



LIGHT DENTAL STUDIOS

Name _____

Height _____ Weight _____

Age _____ Male / Female _____

STOP-BANG Sleep Apnea Questionnaire

STOP		
Has anybody told you that you SNORE ?	Yes	No
Do you often feel TIRED , fatigued, or sleepy during the daytime?	Yes	No
Has anyone OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE ?	Yes	No

Office Use **ONLY** below this line

BANG		
BMI more than 35kg/m ² ?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
Gender: MALE ?	Yes	No

TOTAL SCORE		

High risk of OSA: Yes 5 – 8

Intermediate risk of OSA: Yes 3 – 4

Low risk of OSA: Yes 0- 2

PUYALLUP – BONNEY LAKE – LACEY AT HAWKS PRAIRIE – LAKEWOOD – PARKLAND – TACOMA MALL BLVD – UNIVERSITY PLACE

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