WOLTER ADVANCED
Dental Care

STOP-Bang Questionnaire

For the Assessment of Obstructive Sleep Apnea Risk

Name: _____ Date: _____

Have you been previously diagnosed with sleep apnea? Yes No

If so, are you currently using CPAP to treat your OSA? Yes No

Please answer the following eight questions ***Yes*** or ***No***

YES	NO	
☐	☐	**Snoring: Do you snore loudly?**
☐	☐	**Tiredness/Fatigue: Do you often feel sleepy during the day, even after a "good" night's sleep?**
☐	☐	**Observed Apnea: Have you ever been told you stop breathing during your sleep?**
☐	☐	**Pressure: Do you have or are you being treated for hypertension?**
☐	☐	**BMI: Do you weigh more for your height than is shown on the table at the right?**
☐	☐	**Age: Are you over 50 years old?**
☐	☐	**Neck size: Is your neck size more than 15¾" or 40 cm?**
☐	☐	**Gender: Are you a male?**

HEIGHT	WEIGHT
4'10	167
4'11	173
5'0	179
5'1	185
5'2	191
5'3	197
5'4	204
5'5	210
5'6	216
5'7	223
5'8	230
5'9	237
5'10	243
5'11	250
6'0	258
6'1	265
6'2	272
6'3	279
6'4	287
6'5	295

Score: Total number of "yes" answers _____

Interpretation:

☐ **High risk of OSA: answered yes to 3 or more questions**
Please take this form to your dentist to discuss your sleep related concerns

☐ **Low risk of OSA: answered yes to 0-2 questions**
Talk with your dentist if you have other sleep complaints