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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STOP-BANG Sleep Apnea Questionnaire**

|  |  |  |
| --- | --- | --- |
| **STOP** | **YES** | **NO** |
| Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)? |  |  |
| Do you often feel **T**IRED, fatigued, or sleepy during the daytime? |  |  |
| Has anyone **O**BSERVED you stop breathing during your sleep? |  |  |
| Do you have or are you being treated for high blood **P**RESSURE? |  |  |

|  |  |  |
| --- | --- | --- |
| **BANG** | **YES** | **NO** |
| **B**MI: more than 35 kg/m2? |  |  |
| **A**GE: over 50 years old? |  |  |
| **N**ECK: circumference>16 in (40 cm) |  |  |
| **G**ENDER: MALE |  |  |

|  |  |  |
| --- | --- | --- |
| Total Score |  |  |

**Yes**

**High risk of OSA: 5-8**

**Intermediate risk of OSA: 3-4**

**Low risk of OSA: 0.2**