Screening for Sleep Disordered Breathing
STOP-BANG Sleep Questionnaire

S (snore)	Have you been told that you SNORE?	Yes	No
T (tired)	Are you often tired during the day?	Yes	No
O (observed)	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	Yes	No
P (pressure)	Do you have or are you being treated for high blood PRESSURE?	Yes	No

B (bmi)	Is your Body Mass Index (BMI) more than 28?	Yes	No
A (age)	Is your AGE over 50 years old?	Yes	No
N (neck)	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	Yes	No
G (gender)	Is your GENDER male?	Yes	No