

STOP-Bang Questionnaire



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Is it possible that you have ...
Obstructive Sleep Apnea (OSA)?

Please answer the following questions to determine if you might be at risk.

1. Snoring?

Do you snore loudly (loud enough to be heard through closed doors or your bed partner elbows you for snoring at night)?

☒ YES ☐ NO

2. Tired?

Do you often feel tired, fatigued, or sleepy during the daytime (such as falling asleep during driving or talking to someone)?

☒ YES ☐ NO

3. Observed?

Has anyone observed you stop breathing or choking/gasping during your sleep?

☒ YES ☐ NO

4. Pressure?

Do you have or are being treated for high blood pressure?

☒ YES ☐ NO

5. Body Mass Index more than 35 kg/m²?

cm / kg: _____ inches / lb: _____ BMI: _____

Height: _____ Weight: _____

6. Age older than 50?

☒ YES ☐ NO

7. Neck size large? (Measured around Adams apple)

☒ YES ☐ NO

8. Is your shirt collar 16 inches / 40cm or larger?

☒ YES ☐ NO

For general population:

Low risk of OSA: Yes to 0-2 questions

Intermediate risk of OSA: Yes to 3-4 questions

High risk of OSA: Yes to 5-8 questions or

- Yes to 2 or more of 4 STOP questions + male gender OR
- Yes to 2 or more of 4 STOP questions + BMI > 35 kg/m² OR
- Yes to 2 or more of 4 STOP questions + neck circumference (17"/43cm in male, 16"/41cm in female)