

SLEEP APNEA HEALTH ASSESSMENT

STOP-BANG Screening Template

Patient Name: _____

Date: _____

Date of Birth: _____

BMI: _____

ASSESSMENT CRITERIA	YES	NO
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Snoring: Do you snore loudly (louder than speaking or through closed doors)?

Tired: Do you often feel tired, fatigued, or sleepy during the daytime?

Observed: Has anyone observed you stop breathing during your sleep?

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

BMI: Is your Body Mass Index greater than 35 kg/m²?

Age: Are you older than 50 years of age?

Neck: Is your neck circumference greater than 16 inches (40cm)?

Gender: Is the patient male?

Total Score (Total "Yes" Answers): _____ / 8

CLINICAL OBSERVATIONS & NOTES

Low Risk: 0-2 | Intermediate Risk: 3-4 | High Risk: 5-8