ORLANDO HEALTH®
1414 Kuhl Ave. • Orlando, FL 32806

STOP-BANG QUESTIONNAIRE

PLACE STAT LABEL HERE

LINE UP PATIENT I.D. LABEL HERE

Patient Name:_____ Date of Birth : _____ Date: _____

YES	NO	
❑	❑	**1. Snoring:** Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
❑	❑	**2. Tiredness/fatigue:** Do you often feel tired, fatigued, or sleepy during the daytime even after a "good" night's sleep?
❑	❑	**3. Observed apnea:** Has anyone has ever observed you stop breathing during your sleep?
❑	❑	**4. Pressure:** Do you have or are you being treated for high blood pressure?
❑	❑	**5. Body Mass Index more than 35?**
❑	❑	**6. Age:** Are you older than 50 years?
❑	❑	**7. Neck size:** Does your neck measure more than16 inches (40 cm around)?
❑	❑	**8. Gender:** Are you male?

_____ Total Yes Responses

Physician Signature: _____ I.D. #: _____ Date: _____ Time: _____

INTERPRETER ONLY

(Please Print)

Name: _____ Agency: _____

Telephone: _____ Language: _____