AMBER DENTAL, PC
GENERAL DENTISTRY

STOP-BANG
Questionnaire

Name _____ Age _____ Date_____

1.	**Snoring** "Do you snore loudly?" (Louder than talking or heard through closed doors)	◯ Yes	◯ No
2.	**Tired** "Do you often feel tired, fatigued, or sleepy during daytime?	◯ Yes	◯ No
3.	**Observed** "Has anyone observed you stop breathing during sleep?"	◯ Yes	◯ No
4.	**Blood Pressure** "Do you have or are you treated for high blood pressure?"	◯ Yes	◯ No
5.	**BMI 30 or greater** See attached chart to determine your BMI	◯ Yes	◯ No
6.	**Age** Age > 50	◯ Yes	◯ No
7.	**Neck Circumference** Males >17 in Females >15 in	◯ Yes	◯ No
8.	**Gender** Male gender	◯ Yes	◯ No

High risk of OSA: "Yes" to three (3) or more items