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Call or text for an appointment

STOP BANG

Screening for: Obstructive Sleep Apnea

Name: _____

S (snore)	Have you been told that you snore?	Yes	No
T (tired)	Are you often tired during the day?	Yes	No
O (obstruction)	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 high blood pressure or on medication to control high blood pressure?	Yes	No

If you answered YES to two or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea. It is recommended that you contact your primary care provider to discuss a possible sleep disorder.

To find out if you are at moderate to severe risk of Obstructive Sleep Apnea, complete BANG questions below.

B (BMI)	Is your body mass index greater than 28?	Yes	No
A (age)	Are you 50 years old or older?	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)	Are you a male?	Yes	No
	Are you aware of clenching and grinding?	YES	NO

The more questions you answer YES to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea.

Name: