INTEGRATED Sleep Care

SLEEP APNEA

STOP/BANG QUESTIONNAIRE:

Question	YES	NO
1. Do you snore loudly?	YES ☐	NO ☐
2. Do you often feel tired, fatigued or sleepy during the daytime?	YES ☐	NO ☐
3. Has anyone observed you stop breathing or choking/gasping during your sleep?	YES ☐	NO ☐
4. Do you have or are being treated for high blood pressure?	YES ☐	NO ☐
5. Body Mass Index more than 35?	YES ☐	NO ☐
6. Age older than 50 years?	YES ☐	NO ☐
7. FOR MALE: Is your neck 17 inches or larger?	YES ☐	NO ☐
FOR FEMALE: Is your neck 16 inches or larger?	YES ☐	NO ☐
8. Gender=Male	YES ☐	NO ☐

TOTAL ☐

IF YOU HAVE MARKED 3 OR MORE "YES" YOU ARE AT HIGH RISK OF HAVING OBSTRUCTIVE SLEEP APNEA

954-289-6106 FAX: 954-337-6101
www.integratedsleepcare.com

14601 SW 29th St. Suite 109 Miramar, FL 33027