McIndoe Clinic
Tauranga

SLEEPMEDIK
Sleep Medicine Clinic

Name: Tel Number: DOB: NHI Number:

Date _____

SLEEP APNOEA SCREENING STOP-Bang Questionnaire

Please answer the following questions to determine if you may be at risk of **Obstructive Sleep Apnoea.**

		Yes	No
S noring	**Do you snore loudly** (loud enough to be heard through closed doors)**?**	☐	☐
T ired	**Do you often feel tired, fatigued, or sleepy during the daytime** (falling asleep while driving or talking to someone)**?**	☐	☐
O bserved	**Has anyone observed you stop breathing or choking/gasping during your sleep?**	☐	☐
P ressure	**Do you have or are being treated for high blood pressure?**	☐	☐
B ody Mass Index	**Is your Body Mass Index (BMI) more than 35kg/m^2?** BMI = Weight (kg) / Height^2 (m)	☐	☐
A ge	**Are you 50 years or older?**	☐	☐
N eck	**Do you have a large size neck?** (measured around Adam's apple) For male, is your shirt collar 17 inches / 43 cm or larger? For female, is your shirt collar 16 inches / 41 cm or larger?	☐	☐
G ender	**Are you male?**	☐	☐

	Yes	No
Total:	☐	☐