THE DENTAL ANESTHESIA CENTER
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Sleep Apnea Risk Questionnaire

Instructions: Please circle yes or no to the following questions.

Q. Have you previously been diagnosed with Obstructive Sleep Apnea? Yes No
If yes, are you satisfied with current treatment? Yes No
If not diagnosed, answer questions 1 through 4

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1. **S:** Do you snore loudly?
(louder than talking or LOUD enough to be heard through closed doors) Yes No

2. **T:** Do you often feel tired, fatigued or sleeping during the daytime? Yes No

3. **O:** Has anyone observed you stop breathing during your sleep? Yes No

4. **P:** Do you have or are you being treated for high blood pressure? Yes No

For office use only:

B: *BMI > 35*
A: *Age > 50*
N: *Neck > 17 Inches Male*
16 Inches Female
G: *Male?*

STOP ≥ 2 yes = high risk OSA
STOP-Bang ≥ 3 = high risk OSA