NJ DENTAL SLEEP MEDICINE CENTER

DR. SUNITA MERRIMAN

STOP and Bang Questionnaire

Date: _____

Patient _____

BLOOD PRESSURE TODAY_____

Do you suffer from Depression/Anxiety?.....YES NO

1. Do you **S**nore loudly (louder than talking or loud enough to be heard through closed doors)?
□Yes □No

2. Do you often feel **T**ired, fatigued, or sleepy during daytime?
□Yes □No

3. Has anyone **O**bserved you stop breathing during your sleep?
□Yes □No

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

5. **B**ody Mass Index (BMI) more than 35 (use the formula to calculate your BMI)?
□Yes □No
BMI Formula: weight (lb) / [height (in)]^2 x 703
BMI =

6. **A**ge over 50 yr old?
□Yes □No

(your height in inches X your height in inches)
7. **N**eck circumference greater than16 inches?
□Yes □No

8. **G**ender male?
□Yes □No

Scoring:

Answering "yes" to three or more of the 8 questions indicates that you are at High Risk for OSA. Answering “yes” to less than three questions indicates that you are at Low Risk for OSA. If you scored in the High Risk for OSA category, a sleep study or an evaluation by a sleep specialist may be warranted.

CURRENT THERAPIES

Have you attempted CPAP therapy?.....YES NO
-If yes, are you able to use it at least 5 nights a week (4 or more hours per night)?.....YES NO

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