

DANBURY HOSPITAL

Sleep Apnea Screening Questionnaire

Adapted from the STOP Questionnaire (Chung et al, Anesthesiology 2008; 108: 812-21)

1. *Snoring*
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

Yes No
2. *Tired*
Do you often feel tired, fatigued, or sleepy during the daytime?

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

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

Yes No
5. *BMI*
BMI more than 35 kg/m²?

Yes No
6. *Age*
Age over 50 yrs. old?

Yes No
7. *Neck circumference*
Neck circumference greater than 40 cm?

Yes No
8. *Gender*
Gender Male?

Yes No

High risk of OSA: answering yes to three or more items

Low risk of OSA: answering yes to less than three items