NEAL FAMILY DENTAL

Sleep Medicine

333 NW 3rd Ave.
Canby, OR 97013

Name: _____
Age: _____ Male/Female: _____

- Have you been diagnosed with Obstructive Sleep Apnea? _____
- Do you have a CPAP or an Oral Appliance? _____
- Are you interested in an Oral Appliance for Oral Sleep Apnea? _____

If No, Stop survey now

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP		
Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed doors)?	YES	NO
Do you feel **TIRED**, fatigued, or sleepy during daytime?	YES	NO
Has anyone **OBSERVED** you stop breathing during your sleep?	YES	NO
Do you have or are you being treated for high blood **PRESSURE**?	YES	NO

Height: _____ Weight: _____

BANG		
BMI more than 35kb/m2?	YES	NO
AGE over 50 years old?	YES	NO
Neck circumference >16in (40cm)?	YES	NO
Gender: Male?	YES	NO

High risk of OSA: Yes 5-8
Intermediate risk of OSA: Yes 3-4
Low risk of OSA: Yes 0-2