Do I Have Sleep Apnea?

Answer the 8 simple questions below:

High Risk = "Yes" to 3 or more

STOP-BANG SURVEY

Snoring — Yes ☐ No ☐

Have you been told that you snore?

Tired — Yes ☐ No ☐

Do you often feel tired, fatigued or sleepy during daytime?

Observed — Yes ☐ No ☐

Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?

Pressure — Yes ☐ No ☐

Do you have high blood pressure or on medication to control high blood pressure?

BMI — Yes ☐ No ☐

Is your body mass index greater than 28?

Age — Yes ☐ No ☐

Are you over 50 years old?

Neck — Yes ☐ No ☐

Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches.

Gender — Yes ☐ No ☐

Are you a male?