RAWA DENTAL SLEEP MEDICINE

BRINGING YOU A MORE RESTFUL SLEEP THROUGH ORAL APPLIANCES

Patient Name: _______________________ Date: ______________

Height: _______________

Weight: _______________

STOP BANG Questionnaire

- Do you **S**nore/ snore loudly?
  - YES NO
- Do you often feel **T**ired, fatigues, or sleepy during the day time?
  - YES NO
- Has anyone **O**bserved you stop breathing during your sleep?
  - YES NO
- Do you have or are you being treated for high blood **P**ressure
  - YES NO
- **B**ody Mass Index (BMI)- will be calculated by office
  -
- Are you over 50 years of **A**ge?
  - YES NO
- **N**eck circumference greater than 17 inches (males)/16 inches (females)- will be measured by office
  -
- **G**ender male?
  - YES NO
- Do you have a family history of **O**bstructive **S**leep **A**pnea (OSA)/ family member who wears a CPAP?
  - YES NO

*If you score 3 or more you fall into the **HIGH RISK** category for **OSA**.*

A sleep study/evaluation by a sleep specialist may be warranted.