



## Stop/Bang Questionnaire

|   |                               |                             |   |        |
|---|-------------------------------|-----------------------------|---|--------|
| <b>SURNAME:</b>   |                               |                             |   |        |
| <b>GIVEN NAME:</b>  |                               |                             |   |        |
| <b>DOB:</b>   |                               |                             |   |        |
| <b>SNORING</b><br>Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?  |                               | YES/NO                      |   |        |
| <b>TIRED</b><br>Do you often feel tired, fatigued or sleepy during the day?   |                               | YES/NO                      |   |        |
| <b>OBSERVED</b><br>Has anyone observed you stop breathing during your sleep?  |                               | YES/NO                      |   |        |
| <b>PRESSURE</b><br>Do you have or are being treated for High Blood Pressure   |                               | YES/NO                      |   |        |
| <b>BODY MASS INDEX</b><br><br>WEIGHT _____ kg<br>_____ cm<br>of 50 years:   |                               | HEIGHT<br>AGE: over the age |   | YES/NO |
| <b>NECK SIZE</b><br>Neck Circumference >40 CM   |                               | YES/NO                      |   |        |
| <b>GENDER MALE:</b>   |                               | YES/NO                      |   |        |
| <b>TOTAL SCORE:</b> 1 POINT FOR EVERY "YES" ANSWER  |                               | _____                       |   |        |
| <b>EPWORTH SLEEPINESS SCALE</b>   |                               |                             |   |        |
| How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you. Using this scale to choose the most appropriate number of each situation: |                               |                             |   |        |
| 0 = would <b>NEVER</b> doze   |                               |                             |   |        |
| 1 = <b>SLIGHT</b> chance of dozing  |                               |                             |   |        |
| 2 = <b>MODERATE</b> chance of dozing  |                               |                             |   |        |
| 3 = <b>HIGH</b> chance of dozing  |                               |                             |   |        |
| It is important that you circle (0-3) on each of the questions  |                               |                             |   |        |
| <b>Situation</b>  | <b>Chance of Dozing – 0-3</b> |                             |   |        |
| Sitting and Reading   | 0                             | 1                           | 2 | 3      |
| Watching Television   | 0                             | 1                           | 2 | 3      |
| Sitting in active in a public place i.e Theatre or Meeting  | 0                             | 1                           | 2 | 3      |
| As a passenger in a car for an hour without a break   | 0                             | 1                           | 2 | 3      |
| Lying down to rest in the afternoon   | 0                             | 1                           | 2 | 3      |
| Sitting and talking to someone  | 0                             | 1                           | 2 | 3      |
| Sitting quietly after lunch (when you've had no alcohol)  | 0                             | 1                           | 2 | 3      |
| In a car, while stopped at the lights   | 0                             | 1                           | 2 | 3      |
| TOTAL SCORE   |                               |                             |   |        |