Appendix B: STOP BANG Questionnaire: Screening Tool for OSA

		YES	NO
S	Do you **snore** (loud enough to be heard through closed doors)?	☐	☐
T	Do you often feel **tired**, sleepy or fatigued during daytime?	☐	☐
O	Has anyone **observed** you stop breathing during your sleep?	☐	☐
P	Do you have or are you being treated for high blood **pressure**?	☐	☐
B	**BMI** greater than 35 kgm/m^2?	☐	☐
A	**Age** greater than 50 years old?	☐	☐
N	**Neck** circumference greater than 40 cm?	☐	☐
G	Male **gender**?	☐	☐

TOTAL "YES" equal to or greater than 5: high probability of OSA