STOP Questionnaire for Obstructive Sleep Apnea (OSA)

**1. Snoring**

Do you ***snore*** loudly (louder than talking or loud enough to be heard through a closed door)? YES NO

**2. Tired**

Do you often feel ***tired***, fatigued or sleepy during the day?

YES NO

**3. Observed**

Has anyone ***observed*** you stop breathing while your sleeping?

YES NO

**4. Blood Pressure**

Do you have or are you being treated for high blood pressure?

YES NO

**5. Diabetes**

Have you been diagnosed with Diabetes?

YES NO

HIGH RISK of OSA: Answering YES to 2 or more questions
LOW RISK of OSA: Answering YES to less than 2 questions

Adapted from: STOP Questionnaire, modified to add Diabetic Risk Group