PLEASE RETURN FORMS BY:
EMAIL: Cal.Bar@ahs.ca or FAX: (403) 955-8634 or MAIL: 1820 Richmond Rd SW, Calgary, AB, T2T 5C7

Alberta Health Services

Date: _____

Name: _____
Date of birth: _____
Healthcare #: _____

Sleep Questions		
1. Do you have sleep apnea?	**Yes** ☐	**No** ☐
2. If yes, is it being treated?	**Yes** ☐	**No** ☐

STOP BANG		
Sleep Apnea Questionnaire Chung F et al Anesthesiology 2008 and BJA 2012		
Please answer the following questions to determine if you may be at risk for sleep apnea.		
1. Do you snore loudly? (louder than talking or loud enough to be heard in other rooms)	**Yes** ☐	**No** ☐
2. Do you often feel tired, fatigued or sleepy during daytime?	**Yes** ☐	**No** ☐
3. Has anyone observed you stop breathing during your sleep?	**Yes** ☐	**No** ☐
4. Do you have or are you being treated for high blood pressure?	**Yes** ☐	**No** ☐
5. Is your BMI (body mass index) more than 35kg/m2?	**Yes** ☐	**No** ☐
6. Is your age over 50 years?	**Yes** ☐	**No** ☐
7. Is your neck circumference > 16 inches (40 cm)?	**Yes** ☐	**No** ☐
8. Is your gender male?	**Yes** ☐	**No** ☐

Answer as many of the above questions as you can. If you're unsure of an answer, skip it and discuss with the registered nurse at your next appointment.