

STOP

QUESTIONNAIRE

Snoring - Tired - Observed - Pressure

Patient Name: _____ Date: _____

Circle Yes or No for each Question			
YES	NO	SNORING	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
YES	NO	TIRED	Do you often feel tired, fatigued, or sleepy during the daytime?
YES	NO	OBSERVED	Has anyone observed you stop breathing during your sleep?
YES	NO	BLOOD PRESSURE	Do you have or are you being treated for high blood pressure?

Guidelines for Scoring/Interpretation:
Answering YES to <u>less</u> than two questions = LOW RISK of Obstructive Sleep Apnea
Answering YES to two or <u>more</u> questions = HIGH RISK of Obstructive Sleep Apnea



VA/DoD Clinical Practice Guideline for the
Management of Chronic Insomnia Disorder and Obstructive Sleep Apnea (Version 1.0–2019)