STOP Sleep Screening Questionnaire*

Name: _____

Date: _____

Completed by: _____

1. **Snoring** Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	☐ Yes ☐ No
2. **Tired** Do you often feel tired, fatigued, or sleepy during daytime?	☐ Yes ☐ No
3. **Observed** Has anyone observed you stop breathing during your sleep?	☐ Yes ☐ No
4. **Blood Pressure** Do you have or are you being treated for high blood pressure?	☐ Yes ☐ No

If you answered "YES" to one or more questions, it is recommended you speak with your family physician.

*Source: Anesthesiology 2008; 108: 812-821