Appendix 1

STOP Obstructive Sleep Apnea Questionnaire

S	Do you snore loudly?	Yes	No
T	Do you feel tired, fatigued, or sleepy during the day?	Yes	No
O	Has anyone observed you stop breathing during your sleep?	Yes	No
P	Do you have or are you being treated for high blood pressure?	Yes	No
-High OSA risk if ≥2 affirmative responses. Low OSA risk if <2 affirmatives responses.			