Night Shift – Exposure Assessment

Company:
Name:

* Please write down any illnesses you have had in the past.

* Read the following questions and indicate the most appropriate answer with a V.
In the case of a pre-placement health examination, fill out the form according to the the most recent night shift at the current workplace. If you have never worked night shifts, fill out the form based on what you know about the type of night shift you would be engaged in later.
(The pre-placement health examination will not be performed if the night shift is not regular and you are not sure whether you are subject to a special health examination. A post-placement health examination will be performed after six months if the night shift is recognized as a harmful factor.)

1. How many years did you work in shifts that include night shifts?
□ Less than 5 years □ 5-9 years □ 10-14 years □ 15-19 years □ 20 years or longer □ N/A
2. Please indicate your work arrangements at your current occupation.
□ 3 shifts □ 2 shifts □ Every other day (24-hour shifts) □ Night shift only □ Other (irregular, etc.)
3. Does your work shift circulate on a regular basis?
□ Yes (☞ Go to 3-1) □ No (☞ Go to 4)
3-1. Does your work shift change in the order of morning shift → evening shift → night shift?
□ Yes □ No
4. How many hours do you have between getting off work before going back?
□ More than 11 hours □ Less than 11 hours
5. How many days did you work night shifts continuously on average over the past year?
□ No continuous days of night shifts □ 2 days □ 3 days □ 4 days □ 5 days or more
6. How does the workload and rest time for night shifts compare to day shifts?
1) Work load: Compared to day shifts □ Similar □ Less □ More
2) Rest time: Compared to day shifts □ Similar □ Less □ More
7. Do you work alone during night shifts?
□ Yes □ No
8. Are the following allowed during night shifts?

Sleeping during night shifts	□ Yes	□ No
Rest area	□ Yes	□ No
Meal time/snack time	□ Yes	□ No
Adjusting your night shift schedule	□ Yes	□ No

9. How many hours do you work a week on average?
□ Less than 40 hours □ 40 hours □ 41-51 hours □ 52-59 hours □ 60 hours or more

Night Shift – Sleep Disorder (Insomnia Index)

Company:

Name:

* Please write down any illnesses you have had in the past.

* Read the following questions and indicate the most appropriate answer with a V.

1-3. Please indicate the intensity of the following problems over the past two weeks.

	None	Low	Medium	High	Very High
1. Difficulties falling asleep	□	□	□	□	□
2. Difficulties sleeping soundly	□	□	□	□	□
3. Waking up easily	□	□	□	□	□

4. How satisfied are you with your current sleeping patterns?
□ Very satisfied □ Satisfied □ Average □ Dissatisfied □ Very dissatisfied

5. How much do you think your sleep disorder interferes with your activities during the day?
(Tired during the day; capabilities, concentration, memory, mood while working at the office or home)
□ Not at all □ Slightly □ Somewhat □ Considerably □ Very much

6. Do people say your quality of life is decreasing because of your sleeping problems?
□ Not at all □ Slightly □ Somewhat □ Considerably □ Very much

7. How concerned are you about your current sleeping problems?
□ Not at all □ Slightly □ Somewhat □ Considerably □ Very much

Night Shift – Sleep Disorder (Daytime Sleepiness)

Company:

Name:

* Please write down any illnesses you have had in the past.

* Read the following questions and indicate the most appropriate answer with a V.

	Not sleepy at all	Slightly sleepy	Sleepy	Very sleepy
1. When sitting down and reading	□	□	□	□
2. When watching television	□	□	□	□
3. When being still in public places like theaters or during meetings	□	□	□	□
4. When riding a bus or taxi for about an hour	□	□	□	□
5. When comfortably laying down while resting in the afternoon	□	□	□	□
6. When sitting down and talking to someone	□	□	□	□
7. When quietly sitting down after lunch	□	□	□	□
8. When driving and stopping for a few minutes because of traffic	□	□	□	□

Night Shift – Sleep Disorder (Quality of Sleep)

Company:

Name:

* Please write down any illnesses you have had in the past.

* Read the following questions and indicate the most appropriate answer with a V.

1-4. Please respond to the questions about sleeping during night shifts over the past month.

1. What time do you go to bed? ( )Hr. ( )Min.

2. How long does it take you to fall asleep? ( )Hr. ( )Min.

3. What time do you wake up? ( )Hr. ( )Min.

4. How many hours of actual sleep do you get? ( )Hr. ( )Min.

5. How many times have you had difficulties falling asleep due to the following reasons?

	None	Less than once a week	1-2 times a week	3 times a week or more
Could not fall asleep within 30 minutes	□	□	□	□
Waking up in the middle of the night	□	□	□	□
Waking up to go to the restroom	□	□	□	□
Difficulties breathing when laying down	□	□	□	□
Because of snoring too loudly or coughing	□	□	□	□
Felt extremely cold	□	□	□	□
Felt extremely hot	□	□	□	□
Because of nightmares or unpleasant dreams	□	□	□	□
Because of pain	□	□	□	□
Other reasons ( )	□	□	□	□

6. How would you rate the quality of your sleep over the past month?
□ Very good □ Overall good □ Overall poor □ Very poor

7. How often did you take medication (sleeping aid) to fall asleep during the past month?
□ None □ Less than once a week □ 1-2 times a week □ 3 times a week or more

8. How often have you struggled to stay awake while driving or eating, or when engaging in social activities over the past month?
□ None □ Less than once a week □ 1-2 times a week □ 3 times a week or more

9. How difficult has it been to complete your work over the past month?
□ Not at all □ Not difficult □ Slightly difficult □ Very difficult

Night Shift – Gastrointestinal Diseases

Company:

Name:

* Please write down any illnesses you have had in the past.

* Read the following questions and indicate the most appropriate answer with a V.

1. In the past three months, how often have you felt uncomfortably full after finishing a one-serving meal?
□ Not at all □ Less than once day a month □ One day a month □ 2-3 days a month
□ Once a week □ More than twice a day □ Almost every day

2. Did the feeling of being (uncomfortably) full after eating occur more than six months ago?
□ No □ Yes

3. How frequently were you unable to finish one serving of food over the past three months?
□ Not at all □ Less than one day a month □ One day a month □ 2-3 days a month
□ Once a week □ More than twice a day □ Almost every day

4. Did the symptoms of being unable to finish one serving of food start more than six months ago?
□ No □ Yes

5. How often have you felt pain or a burning sensation in the center of your stomach (not your chest, but above your belly button) over the past three months?
□ Not at all □ Less than one day a month □ One day a month □ 2-3 days a month
□ Once a week □ More than twice a day □ Almost every day

6. Did the stomach pain or burning symptoms start more than six months ago?
□ No □ Yes

Night Shift – Breast Cancer

Company:

Name:

* Please write down any illnesses you have had in the past.

* Read the following questions and indicate the most appropriate answer with a V.

1. The recommended early screening cycle for breast cancer in South Korea is as follows. Have you taken early screening for your age so far?

- 30 and older: Self-diagnosis every month
- 35 and older: Examined by a physician every two years
- 40 and older: Examined by a physician with mammography every one to two years

□ Almost never
□ A few times
□ Every time

2. Please indicate all of your current symptoms.
□ I feel a lump in my breast.
□ There is secretion from a nipple.
□ My nipple is cracking up or sunken.
□ No symptoms.

3. Have you had a breast X-ray or sonogram in the past year?
□ No □ Yes