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.

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. How often did you self-diagnose for breast cancer over the past year?
□ Never □ Less than once every six months □ Once every 3-6 months
□ Once every 1-2 months □ More than twice a month

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