Questionnaire for statutory checkup Night work

Name	Social Security Number	Date

Marital status

☐ Single ☐ Married/Partner ☐ Living apart

Number of children living home: _____

Work

What are your duties? _____

When (year) did you start working with your current duties? _____

Do you work extra in your spare time? ☐ Yes ☐ No

Duty ratio in %: _____

☐ Night-work only ☐ Two-shift ☐ Three-shift ☐ Other:

Are you working overtime? Specify the average number of hours per month: _____

How are your nightwork scheduled? ☐ Occasional night work sessions ☐ Up to 3 consecutive night work sessions ☐ > 3 consecutive night work sessions

How many nights do your work per month? _____

How many years have you had working hours that include night work? _____

Have you tried to change working hours the last year? ☐ Yes ☐ No

Diseases

Do you have any disease that you are being treated for? ☐ Yes ☐ No

If yes, state which disease(s): _____

Do you use sedative medicine or sleep medicine? ☐ Yes ☐ No

Do you use other medicines? If yes, indicate which: _____

Do you currently consider yourself fully healthy? ☐ Yes ☐ No

Physical exercise

How often during a normal week do you do physical exercise that makes you breathless, for example running, keep-fit exercises or ball games?

☐ No time ☐ 30 minutes ☐ 60 minutes ☐ 90 minutes ☐ 120 minutes ☐ 150 minutes or more

How much time during a normal week do you get ordinary exercise in,for example, walking, cycling or gardening?

☐ No time ☐ 30 minutes ☐ 60 minutes ☐ 90 minutes ☐ 120 minutes ☐ 150 minutes or more

Food & nutrition

How often do you eat fruit and vegetables?

☐ Twice a day or more ☐ Once a day ☐ A few times a week ☐ Once a week or less ☐ Never or almost never

Hur ofta äter du kaffebröd, choklad/godis, chips eller läsk/saft?

☐ Twice a day or more ☐ Once a day ☐ A few times a week ☐ Once a week or less ☐ Never or almost never

How do you distribute your meals around the clock?

☐ Morning, dinner and evening as well as snacks. Enter approximately when: _____

☐ Morning, dinner and evening. Enter approximately when: _____

☐ Only two meals per day. Enter approximately when: _____

☐ Only one meal per day. Enter approximately when: _____

Do you eat breakfast before going to bed after working night? ☐ Yes ☐ No

Tobacco

Smoking habits

☐ I have never smoked
☐ I stopped smoking more than 6 months ago
☐ I stopped smoking less than 6 months ago
☐ I smoke 1–9 cigarettes per day
☐ I smoke 10–19 cigarettes per day
☐ I smoke more than 20 cigarettes per day

Moist snuff habits

☐ I have never used moist snuff
☐ I stopped using moist snuff more than 6 months ago
☐ I stopped using moist snuff less than 6 months ago
☐ I use 1–3 cans of moist snuff per week
☐ I use 4–6 cans of moist snuff per week
☐ I use more than 7 cans of moist snuff per week

Alcohol

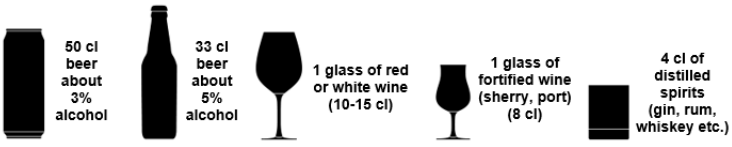
How often do you drink alcohol?

☐ Never
☐ 1 time/month or more rarely
☐ 2–4 times/month
☐ 2–3 times/week
☐ 4 times/week or more

How many “glasses” do you drink on a typical day when you drink alcohol?

☐ 1–2
☐ 3–4
☐ 5–6
☐ 7–9
☐ 10 or more

Examples of glass meant:



Drugs

Have you tried drugs? ☐ Yes ☐ No

If yes, what, when and to what extent?

_____

_____

_____

Well-being

The following questions relate to how you have had it over the past 4 weeks.

	All the time	A large part of the time	Part of the time	A small part of the time	Not at all
How often have you had trouble relaxing?	☐	☐	☐	☐	☐
How often have you been stressed?	☐	☐	☐	☐	☐
How often have you lacked stamina and energy?	☐	☐	☐	☐	☐
How often have you slept poorly or worried?	☐	☐	☐	☐	☐
How often have you had trouble falling asleep?	☐	☐	☐	☐	☐
How often have you woken up too early and found it difficult to fall asleep?	☐	☐	☐	☐	☐
How often have you woken up several times and found it difficult to fall asleep?	☐	☐	☐	☐	☐

Are you satisfied with your current sleep pattern?	☐ Yes	☐ No

Heredity and background

	Yes	No	Don't know
Have you or have you had a cardiovascular disease?	☐	☐	☐
Have any of your male biological relatives (parent or sibling) suffered from myocardial infarction (heart attack) / cerebrovascular (stroke or blockage of blood vessels in the brain) disease before the age of 55?	☐	☐	☐
Have any of your female biological relatives (parent or sibling) suffered a heart attack/ clog in the brain before the age of 65?	☐	☐	☐
Did any of your biological parents or siblings have type II diabetes?	☐	☐	☐