

Questionnaire for medical examination Night work

Name	Social Security Number	Date
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Night Work

According to the Swedish Work Environment Authority's regulations on medical checks in working life, AFS 2019: 3, the worker must be offered a medical examination before night work is started for the first time and then be offered a free medical examination every six years, after the age of 50, every three years. The background to the Swedish Work Environment Authority's regulations is that research has shown that night work is associated with various health effects. Several scientific studies have shown a superficiality in cardiovascular disease and sleep disorders in workers with shift work. In addition, there is an increased risk of accidents due to night work.

Employees covered are those who normally carry out at least 3 hours of their work period between 10 p.m and 3 a.m or who will probably fulfill at least one-third of their annual working hours between 10 p.m and 6 a.m. Night work is not intended for employees who for one year have one or more jobs with night work, where the total duration of employment is less than 3 months.

Personal data

Man	Woman	
Single	Married/partner	Living apart
Number of children living at 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
Are your working hours scheduled to some extent with at least three hours in the time interval between 10 p.m and 6 a.m?			Yes No
Working time?			
Nightwork only	Two-shift	Three-shift	Other:
Regular working hours on average		hours per week	
Are you working overtime? Specify the average number of hours per month:			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?		nights per month	
How many years have you had working hours that include night work?			years
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 feel that the risk of accidents is increased because you work at night?	Yes	No

Meals

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:

What do your meals look like?

Usually a versatile diet prepared on basic products	Usually sandwiches
Usually fast and ready food	Usually cookies, biscuits, sweets and chips

How often do you eat breakfast?

Daily	Once a week or more rarely
Almost every day	Never/Almost never
Several times a week	
Do you eat a big breakfast before going to bed after working night?	Yes No


Are you satisfied with your eating habits?	Yes	No
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Alcohol and tobacco habits

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 are meant:				
				

Have you been treated in the hospital or treated by a doctor for illness since the previous regular health check?	Yes	No
Have you been on sick leave for more than four weeks since the last health check or had repeated short-term absence? (6 times or more over a 12-month period)	Yes	No
Do you currently consider yourself to be fully healthy?	Yes	No
Do you use tobacco?	Yes	No
If you answered Yes to the above question, do you smoke?	Yes	No

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 irritable?				
How often have you been tense?				
How often have you been stressed?				
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?				
How often have you felt powerless and energyless?				
How often have you been physically exhausted?				
How often have you felt tired?				

Are you satisfied with your current sleep pattern?	Yes	No
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Heredity and background

Yes No I 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?			
Have you been told that your blood pressure is elevated?			