Night Shift – Exposure Assessment

* 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)

* 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 – 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