Questionnaire for statutory checkup Night work

Name	Social Security Number	Date

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	◯ Other
◯ 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		
Are your working hours scheduled to some extent with at least three hours in the time interval betweebn 10 p.m and 6 a.m?	◯ Yes	◯ No		
Working time?				
◯ Night-work 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 as well as snacks. 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

Alcohol and tobacco habits

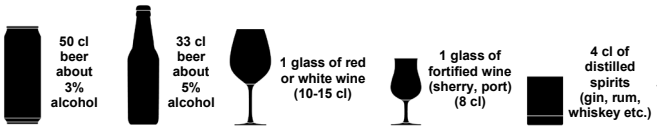
How often do you drink alcohol?

◯ 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 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

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?	◯	◯	◯