Korean Society of Occupational & Environmental Medicine Special Health Examination Revised Issue

Company:

Name:

※ Questions on Medical History (Patient History, Family History)

※ Please read the following questions and indicate with [**O**] for **current state**.

1. Have you been **diagnosed or are you currently taking medication for any of the following illnesses**?

Illness	Stroke	Heat disease (Myocardial infarction/ Angina pectoris)	High blood pressure	Diabetes	Dyslipidemia	Tuberculosis	Others (including cancer)
Diagnosis							
Medical treatment							

2. Have any of your **parents, brothers, or sisters died from the following illnesses**?

Illness	Stroke	Heat disease (Myocardial infarction/Angina pectoris)	High blood pressure	Diabetes	Others (including cancer)
Yes					

3. Are you a **hepatitis B virus** carrier? ① Yes ② No ③ Don’t know

※ Smoking

4. Please read the following and indicate your **current status**.

4-1. Have you smoked more than five packs (100 sticks) of cigarettes over your entire life?

① No (☞ Go to question 5)

② Yes, but I have quit now (☞ Go to Question 4-2)

③ Yes, and I am still smoking (☞ Go to Question 4-3)

4-2. If you have **smoked in the past**, but have since quit:

How many years did you smoke before quitting?	Total __________years
How many cigarettes did you smoke a day before quitting?	_______cigarettes

4-3. If you are **still smoking:**

For how many years have you smoked?	Total __________years
How many cigarettes do you smoke a day on average?	_______Cigarettes

※ Alcohol

5. Please read the following and indicate your **current status**.

5-1. How often do you drink each week?

□0 □1 □2 □3 □4 □5 □6 □7

5-2. When you drink, **how much do you drink a day**? (※ Regardless of the type of alcohol)
(glasses)

※ Physical Activity (Exercise)

6. Please read the following questions and indicate **activities undertaken in the past week** with a '√' mark.

6-1. In the past week, how many days did you engage in intense physical activities that made you breathe much more heavily than normal for more than 20 minutes (i.e.: running, aerobics, fast-speed cycling, hiking, etc.)?

□0 □1 □2 □3 □4 □5 □6 □7

6-2. In the past week, how many days did you engage in medium-level physical activities that made you breathe a bit more heavily than normal for more than 30 minutes (i.e.: walking at a fast pace, tennis doubles, cycling at normal speeds, wiping the floor face down)? ※ Excluding physical activities related to answers in 6-1

□0 □1 □2 □3 □4 □5 □6 □7

6-3. In the past week, how many days did you walk for more than 30 minutes, and at least 10 minutes per occasion (i.e.: light exercise, including walking to and from work, or for leisure)?

※ Excluding physical activities related to answers in 6-1 and 6-2

□0 □1 □2 □3 □4 □5 □6 □7

※ Questions about symptoms related to target organs

7. Please respond relating to symptoms experienced in the past six months.

Body Part	Symptoms	Intensity		
		High	Medium	None
General	Lost appetite and weight			
	Feeling of fatigue often			
	Lumps felt in the body			
Skin	Itchy feeling or inflammations			
	Skin rashes			
	Changes to the hair, fingernails, or toenails			
	Skin becomes rough and cracked			
Eyes	Eyes are irritated and tear up more often			
	Eyesight worsening			
	Eyes become bloodshot or hurt			
Ears	Cannot hear clearly			
	Ringing in the ears			
Nose	Frequent nosebleeds			
	Runny or stuffy nose			
	Difficulties smelling			
Mouth	Bloody gums or canker sores			
	Difficulties tasting			
Digestive	I have felt a stinging pain in my stomach.			
	Metallic taste in my mouth			
	Constipation			
Cardiovascular/ Respiratory	Palpitation while working			
	Coughing and shortness of breath while working			
	Chest pressure			
	Coughing or spitting phlegm when waking up			
	Coughing when returning to work after a holiday			

Body Part	Symptoms	Intensity		
		High	Medium	None
Spine/Limbs	Arms, legs, and shoulder aches			
	Trembling or weak hands and feet			
	Hands and feet feeling numb			
	Fingers becoming white when cold			
	Back pain			
Mental/Nervous System	Headaches			
	Dizziness			
	Worsened memory and forgetfulness			
	Anxiety and restlessness			
	Head feels numb or feels as if I am drunk			
	Difficulties concentrating			
Urinary/ Reproductive	Difficulties urinating			
	Body swelling			
	Irregular menstruation			
	Experienced a miscarriage			

If you have had any other symptoms, please describe them in the field below.

*** Have you ever experienced health problems (physical problems) during work?** □ **Yes** □ **No**

*** Do you think that you have health problems due to the materials you handle at work?** □ **Yes** □ **No**

Doctor's Comments	

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