

ID Number	A1-2003-0052-Eng
Title	Worker's Health Survey in Korea : Non-manufacturing Worker, 2003

Company Name		Company Code_	
Respondent Name		Sex	1) Male 2) Female
Age	_____ (years)	Department	
Work Phone Number		Mobile Phone Number	
Home Address	_____ City/Province	_____ City/County/District	_____ Eup/Myeon/Dong _____ Street Number/APT# _____ - _____
Interviewer Name		Interview Time and Date	(date) : (time) (Duration: _____ minutes)
Reviewer Name		Review Outcomes	

I. FIRST, I AM GOING TO ASK YOU ABOUT YOUR HEALTH.

Q1. Over the past 2 weeks, have you felt any physical discomforts? Not to mention chronic diseases you might have, if you have had any discomforts such as light headaches, minor wound, rash, fatigue, hangover, toothache, menstrual cramps, and so on, please tell me so.

- * Any physical discomfort that started sometime before 2 weeks ago and has lasted since then, please include it in your answer as well.
 - * "Past 2 weeks" means "from [] day of the week before last week to today."
- 1) Yes ⇒ Go to the Q2
2) No ⇒ Go to the Q7

Q2. For each and every physical discomfort you have, please tell me what it is (symptom) and which part of your body you mostly feel it.

	Pain 1	Pain 2	Pain 3	Pain 4	Pain 5 (Musculoskeletal discomfort only)
2-1. What it is					
2-2. Body part					

- 2.1. [Symptoms]**
- If there are a number of symptoms to list, please write up to 4 symptoms in "Symptom 1 through Symptom 4." Under "Symptom 5," please write in musculoskeletal system (bone/muscle) related pains only.
 - If you have a complex discomfort such as "headache and shoulder pain," please treat it as one symptom and write it in a single cell.

- However, if you visited multiple healthcare facilities due to the complex discomfort, for example, if you saw an orthopedist for shoulder pain, and went to a pharmacy because of headache, please write each symptom separately.
- However, if the orthopedist treated the headache as well, please write in the complex discomfort as one single symptom.

2-2. [Body parts]

- Please write in details as much as possible (example: tooth, gum, tongue, lips, jaw, etc.).

Q3. Please record your answers for Q3-1 through Q3-9 in the answer sheet below Q3-9 (page 3).

Q3-1. When did you first feel the symptom you listed in Q2?

Q3-2. How serious do you feel this symptom is?

- 1) Not serious at all
- 2) Not very serious
- 3) I don't know (Moderately serious)
- 4) Somewhat serious
- 5) Very serious

Q3-3. Do you still feel the symptom? Or is it gone?

- 1) I still feel it ⇒ Go to the Q3-4
- 2) It is gone
- 3) I don't know ⇒ Go to the Q3-4

Q3-3-1. When did the symptom disappear? Please write the date (___month ___day) last time you felt that symptom.

Q3-4. Do you think that the work you are doing in your company is related to the occurrence or worsening of the symptom?

Not related at all	Not very related	Moderately related (I don't know)	Somewhat related	Very related
1	2	3	4	5

Q3-5. Then, do you think working environment of your company is related to the occurrence or worsening of the symptom?

Not related at all	Not very related	Moderately related (I don't know)	Somewhat related	Very related
1	2	3	4	5

Q3-6. Have you visited healthcare facilities, such as hospitals, oriental doctors, pharmacies, or a health service office in your workplace because of this symptom?

- 1) Yes ⇒ Go to the Q3-8
- 2) No ⇒ Go to the Q3-7

Q3-7. What is the reason why you did not visit any healthcare facilities, even if you felt physical discomforts? (Go to the Q3-9 after answer this question.)

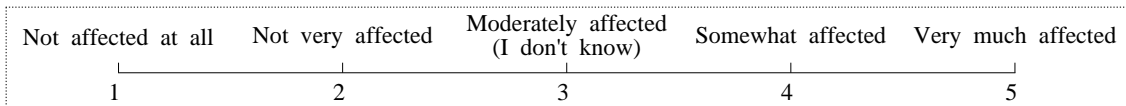
- 1) It was just a minor symptom
- 2) Medical visit is costly
- 3) I had no time
- 4) It cannot be cured

- 5) Medical facilities are too far
- 6) Treatment is planned.
- 7) Other ()
- 8) Not applicable (Treated)
- 9) I don't know

Q3-8. Then which of the following healthcare facilities did you visit? (Record all facilities you visited in order of frequency.)

- 1) Health service office in the workplace
- 2) Pharmacy
- 3) Doctor's office
- 4) Hospital
- 5) General hospital
- 6) University hospital
- 7) Oriental doctor/hospital
- 8) Public health center
- 9) Other

Q3-9. How much is your daily life affected by the symptom?



© Answer sheet for Questions 3-1 through 3-9

	Pain 1	Pain 2	Pain 3	Pain 4	Pain 5 (Musculoskeletal discomfort only)
3-1. First time felt	___ (year) ___ (month) ___ (day)	___ (year) ___ (month) ___ (day)	___ (year) ___ (month) ___ (day)	___ (year) ___ (month) ___ (day)	___ (year) ___ (month) ___ (day)
3-2. Seriousness					
3-3. Lasting or not	1) Last 2) Gone (__month__day) 3) Don't know	1) Last 2) Gone (__month__day) 3) Don't know	1) Last 2) Gone (__month__day) 3) Don't know	1) Last 2) Gone (__month__day) 3) Don't know	1) Last 2) Gone (__month__day) 3) Don't know
3-4. Work-related?					
3-5. Working environment-related?					
3-6. Healthcare facility visit	1) Visited 2) Not visited	1) Visited 2) Not visited	1) Visited 2) Not visited	1) Visited 2) Not visited	1) Visited 2) Not visited
3-7. Reason for not being treated					
3-8. Healthcare facilities visited					
3-9. Level of influence on daily life					

Q4. Have you visited any healthcare facility to treat the symptoms you listed above?

- 1) Yes ⇒ Go to the Q5
- 2) No ⇒ Go to the Q6

Q5. If you visited a healthcare facility to treat your symptoms, please write your answers for Q5-1 through Q5-4 in the answer sheet below Q5-4.

Q5-1. How did the health care facility diagnose the symptom?

Q5-2 Over the past 2 weeks, how many times have you visited healthcare facilities? (Multiple visits made in a single day should be counted as one (1) visit.)

Q5-3. Over the past 2 weeks, how much did you pay to the health care facilities you visited regarding this symptom?

Q5-4. Is this symptom completely cured?

(In other words, is this symptom completely gone so you do not need to take any medicine or make medical visits regarding this symptom anymore?)

- 1) Completely cured
- 2) Not completely cured

◎ Answer sheet for Questions 5-1 through 5-4

Symptom number	Pain 1		Pain 2		Pain 3		Pain 4		Pain 5 (Musculoskeletal discomfort only)	
5-1. Diagnosis										
5-2. Number of visits	___ times		___ times		___ times		___ times		___ times	
5-3. Medical cost	___ won		___ won		___ won		___ won		___ won	
5-4. Completely cured or not	1	2	1	2	1	2	1	2	1	2

Q6. Over the past 2 weeks, have you come to work late, taken work hours off, left work early, or taken a whole day off because you were not feeling well? If so, how many days? Please tell me every incident regardless it was officially recorded or not. (Write “None” if there was no such incident.)

Q6-1. To which symptom was it attributed?

	(1) Late for work	(2) Taking work hours off	(3) Leaving work early	* (4) Absent from work	(5) Sick days	* (6) Bed rest
6. Number of days	___ days	___ days	___ days	___ days	___ days	___ days
* 6-1. Related symptom number	Number ___	Number ___	Number ___	Number ___	Number ___	Number ___

* (4) (Number of days) Absent from: Includes paid-time-offs, except for sick days.

- * (6) (Number of days) Bed rest : Being hospitalized or in-home bed rest.
- * 6-1. Related symptom number: Copy "Symptom numbers" from Q5.

Q7. Over the past 2 weeks, have you ever taken or used any medicine (by mouth or on your skin)? (If there is any medicine (or herbal/tonic medicine) you have taken for a long period of time, please include it even if you did not take it in the past 2-weeks period.)

- 1) Yes
- 2) No ⇒ Go to II.WORK AND WORKING ENVIRONMENT

Q8. The following are Questions 8-1 through 8-8. Please write your answers in the answer sheet below Q8-8.

Q8-1. What is the name of the medicine? Please tell me its brand name or type of medicine. (If it is a mixture (preparation), write "mixture.")

Q8-2. Do you take or use this medicine regularly? Or occasionally?

- 1) Regularly (every ___days)
- 2) Occasionally

Q8-3. How many total days have you taken/used this medicine?

Q8-4. How often do you take/use this medicine per day? What is the amount of medicine you take each time? (e.g., ___ pills, ___ pouches, ___ ml, etc.)

Q8-5. Is this medicine related to any of those symptoms you listed above? If so, which symptom? (Write the symptom number.)

- 1) Yes – Symptom number ()
- 2) No

Q8-6. After taking the medicine, did you get the result you expected?

- 1) Yes
- 2) No

Q8-7. For what reason did you take/use this medicine?

Q8-8. Where did you buy this medicine?

© Answer sheet for Questions 8-1 through 8-8

	Medicine 1	Medicine 2	Medicine 3	Medicine 4	Medicine 5
8-1. Medicine name					
8-2. Regularly or not	1) Regularly (every ___ days)	1) Regularly (every ___ days)	1) Regularly (every ___ days)	1) Regularly (every ___ days)	1) Regularly (every ___ days)
	2) Occasionally	2) Occasionally	2) Occasionally	2) Occasionally	2) Occasionally

8-3. Total number of days on medication	___ days	___ days	___ days	___ days	___ days
8-4. Daily dose	___ (times) per day ___ each time	___ (times) per day ___ each time	___ (times) per day ___ each time	___ (times) per day ___ each time	___ (times) per day ___ each time
8-5. Related symptom	1) Related/ Symptom number () 2) Not related	1) Related/ Symptom number () 2) Not related	1) Related/ Symptom number () 2) Not related	1) Related/ Symptom number () 2) Not related	1) Related/ Symptom number () 2) Not related
8-6. Effectiveness					
8-7. Reason for taking/using					
8-8. Medicine vendor					

II. WORK AND WORKING ENVIRONMENT

Q1. Over the past 1 week, how many hours did you work total? (Please include hours spent on overtime work and break. Exclude mealtime breaks.)

- Total number of hours worked past week: _____

Q1-1. Among the total hours worked in the past 1 week you listed above, how many hours did you work over time?

- Number of hours worked overtime past week: _____

Q1-2. Last week, from what time to what time were the official working hours on weekdays in your workplace?

- From ____:____ (1) am 2) pm)) to ____:____ (1) am 2) pm)

Q1-3. Over the past 1 week, did you have officially set breaks during work on weekdays (excluding mealtime breaks)?

- 1) Yes ⇒ Go to the Q 1-3-1
- 2) No ⇒ Go to the Q 1-3-2

Q1-3-1. If you had breaks that were officially set, how many breaks did you usually have per day? How long did each break last?

- Number of breaks per day _____times
- Duration of each break _____minutes

(If each break lasts for different periods, record the duration of each break separately.)

Q1-3-2. If you did not have official breaks, how freely were you able to take a break unofficially during working hours?

- 1) I have almost no freedom to take a break.
- 2) I hardly have freedom to take a break. (Average hours of breaks per day: ___ hours)
- 3) I have limited freedom to take a break. (Average hours of break per day: ___ hours)
- 4) I have some freedom to take a break. (Average hours of breaks per day: ___ hours)
- 5) I have freedom to take a break whenever I need to.
(Average hours of breaks per day: ___ hours)

Q2. Do you work in shifts?

- 1) Yes
- 2) No

Q2-1. If you work in shifts, what type of work shift is it?

						Response
1) Type of shifts	(1) Double shift	(2) Triple shift	(3) Quadruple shift	(4) Other (___)		
2) Number of teams in shifts	(1) 2-team	(2) 3-team	(3) 4-team	(4) 5-team	(5) Other (___)	
3) Continuity pattern*	(1) Continuous	(2) Semi-continuous	(3) Discontinuous			
4) Fixed or rotating*	(1) Fixed shift	(2) Clockwise rotating	(3) Counter-clockwise rotating			
5) Shift intervals	(1) Weekly basis	(2) Bi-weekly basis	(3) Monthly basis	(4) Quarterly basis		

- * 3) Continuous shift: Operated continuously throughout 7 days a week, 24 hours a day
 Semi-continuous shift: Operated continuously 5 days a week, 24 hours a day. No work on weekend.
 Discontinuous shift: Operated less than 24 hours a day, no work on weekend.
- * 4) Clockwise rotating: Rotates in an order of day-evening-night.
 Counter-clockwise rotating: Rotates in an order of night-evening-day.

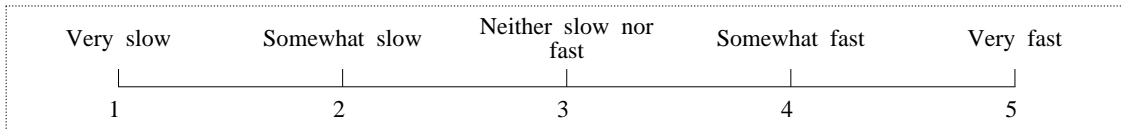
Q2-2. How satisfied are you with the current shiftwork system?

Very dissatisfied	Dissatisfied	Neither dissatisfied nor satisfied	Satisfied	Very satisfied
1	2	3	4	5

Q3. Which of the following do you think best describes the labor intensity of your work?

- 1) Very easy as if I was lying on my back.
- 2) Easy
- 3) Somewhat easy
- 4) Somewhat strenuous
- 5) Strenuous
- 6) Very strenuous
- 7) Extremely strenuous that I have never done before in my life

Q4. How slow or fast do you think the pace of your work is?



Q4-1. On which of the following do you think the pace of your work is mostly dependent?

- 1) My work should be done at a steady pace in accordance with automatic speed of machine
- 2) It does not have to be a steady pace in accordance with automatic speed of machine or movement of product. However, I have to keep up the speed to maintain certain amount of spare products.
- 3) There is no required pace of work (such as speed of machine or conveyer line) I have to follow. I get paid by the number of pieces I produce per day.
- 4) There is no required pace of work (such as speed of machine or conveyer line) I have to follow. All I have to do is to meet the daily production targets or performance targets.
- 5) There is no required pace of work (such as speed of machine or conveyer line) I have to follow. I have to keep up the pace based on demands or suggestions from my coworkers, boss, or customers.
- 6) In my work, there is no required pace of work or daily production/performance targets I have to meet.

Q5. To what extent are you able to control the pace of your own work?

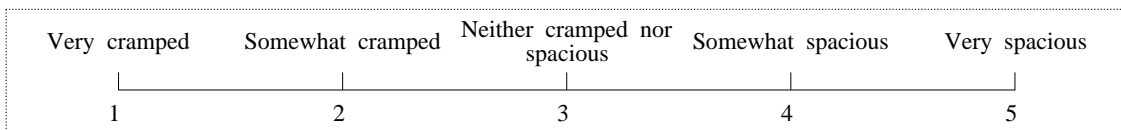
- 1) I have almost no control
- 2) I hardly have any control
- 3) I have half the control
- 4) I have some control
- 5) I have almost the full control

Q6. Is your work mostly done in one place? Or is it done in two or more places?

(If one or more hours of work is done in the space beyond the radius of 5m or greater, it should be counted as two or more places. "Done in two or more places" may include cases such as 1) transporting products from one place to another and working on them, 2) simultaneously managing several devices within a building, etc.)

- 1) Done in one place
- 2) Done in two or more places

Q6-1. How cramped or spacious do you think your work space is?



Q7. How much concentration is required during your work?

- 1) Concentration is not at all required.
- 2) Concentration is hardly required.
- 3) Half-concentration is required.
- 4) Some concentration is required.
- 5) Concentration is required throughout the work.

Q8. What is a ratio between work while sitting and work while standing in your current job?

- 1) I always work while sitting
- 2) I tend to work while sitting
- 3) I work while sitting and standing, half and half
- 4) I tend to work while standing
- 5) I always work while standing

Q9. Which part of your body is most frequently used for the work you are doing?

- 1) Fingers, hands, wrists
- 2) Arms, shoulders
- 3) Ankles, knees, legs
- 4) Lower back
- 5) Other ()

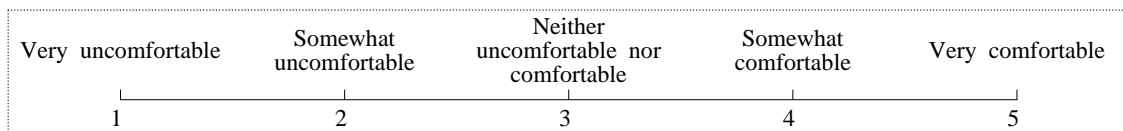
Q10. How much of your job involves repetitive tasks?

- 1) There are practically no repetitive tasks in my job.
- 2) There are not much of repetitive tasks in my job.
- 3) Half of my job involves repetitive tasks.
- 4) Significant amount of my job involves repetitive tasks.
- 5) My job involves repetitive tasks almost all the time.

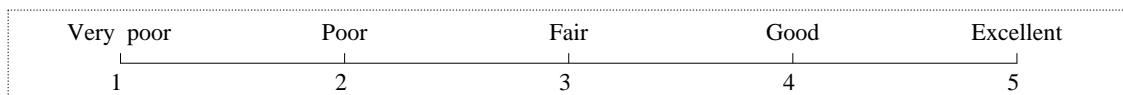
Q10-1. Which part of your body is most frequently used for repetitive tasks?

- 1) Fingers, hands, wrists
- 2) Arms, shoulders
- 3) Ankles, knees, legs
- 4) Lower back
- 5) Other ()

Q11. How uncomfortable or comfortable do you feel with the work you are doing now?



Q12. How do you feel about the physical working environment in your workplace?



Q12-1. If the physical environment of your workplace is poor, which of the following kinds of issues is there?

Q12-2. Then, how serious do you think the issue is?

Not serious at all	Not very serious	Moderately serious	Somewhat serious	Very serious
1	2	3	4	5

	12-1. Has an issue?	12-2. Level of seriousness				
1) Too cold	1) Yes 2) No	1	2	3	4	5
2) Too hot	1) Yes 2) No	1	2	3	4	5
3) Workspace is crowded and messy	1) Yes 2) No	1	2	3	4	5
4) Supplies are not adequate and inconvenient.	1) Yes 2) No	1	2	3	4	5
5) Dirty and unhygienic	1) Yes 2) No	1	2	3	4	5
6) Rest area and cafeteria, etc. are inadequate.	1) Yes 2) No	1	2	3	4	5
7) Too noisy	1) Yes 2) No	1	2	3	4	5
8) Facilities are not suitable for the tasks.	1) Yes 2) No	1	2	3	4	5
9) There is no hazardous substance, but ventilation is poor.	1) Yes 2) No	1	2	3	4	5
10) Exposed to hazardous substance	1) Yes 2) No	1	2	3	4	5
11) Dim lights in the workplace	1) Yes 2) No	1	2	3	4	5
12) No windows	1) Yes 2) No	1	2	3	4	5
13) Inadequate humidity	1) Yes 2) No	1	2	3	4	5
14) Air quality is poor because of dust, gas, fume, smoke, etc.	1) Yes 2) No	1	2	3	4	5
15) It has many dangerous machines.	1) Yes 2) No	1	2	3	4	5
16) There is a risk of traffic accidents.	1) Yes 2) No	1	2	3	4	5

Q13. Are you handling hazardous substance at work?

- 1) Yes
- 2) No

Q13-1. How often are you exposed to hazardous substance?

Not at all	Rarely	Don't know	Sometimes	Very often
1	2	3	4	5

Q13-2. Are you aware of safety rules for used of hazardous substance?

- 1) Yes
- 2) No

Q13-3. Have you heard of Material Safety Data Sheet (MSDS)?

- 1) Yes
- 2) No ⇒ Go to the Q14

Q13-3-1. If you have heard of Material Safety Data Sheet (MSDS), have you ever read it?

- 1) Yes
- 2) No

Q13-3-2. Is Material Safety Data Sheet (MSDS) in your workplace so anyone can read it if necessary?

- 1) Yes
- 2) No
- (3) Don't know

Q14. For each of the following statements, please select one response option which is closest to your opinion.

	Not true at all	Not very true	Moderately true	True	Very true
1) I really have to work very hard	1	2	3	4	5
2) My job duties are beyond my ability	1	2	3	4	5
3) It is hard for me to get the job done within given time	1	2	3	4	5
4) I do not have to do repetitive tasks	1	2	3	4	5
5) The task I am going is something creative	1	2	3	4	5
6) I learn a lot from the work I am doing	1	2	3	4	5
7) I have a lot to say about accidents happened while I was doing my job	1	2	3	4	5
8) I am able to determine the methods of work I am doing	1	2	3	4	5
9) I am working with other people's help	1	2	3	4	5
10) I am working together with people who are personally interested in me	1	2	3	4	5
11) My supervisor is helpful	1	2	3	4	5
12) My supervisor cares about my welfare	1	2	3	4	5
13) I feel energyless	1	2	3	4	5
14) I feel exhausted even I had a sound sleep the previous night	1	2	3	4	5
15) I have no appetite	1	2	3	4	5
16) I am not able to get sound sleep	1	2	3	4	5
17) Sometimes I am anxious	1	2	3	4	5
18) I am depressed	1	2	3	4	5
19) Everything is bothering me	1	2	3	4	5

20) It is impossible for me to concentrate on working	1	2	3	4	5
21) I am tired after a day's work	1	2	3	4	5
22) Sometimes I get nervous	1	2	3	4	5

III. SMOKING

Q1. Do you currently smoke cigarettes?

- 1) Yes ⇒ Go to the Q1-1
- 2) I used to smoke, but not any longer .⇒ Go to the Q2
- 3) Never ⇒ Go to IV. DRINKING

Q1-1. (Current smokers only) At what age did you first smoke a cigarette? (Please recall the time when you first smoked one full cigarette.)

- Age of first cigarette smoking: _____ years of age

Q1-2. Over the past 1 month, how many cigarettes do you usually smoke per day? (⇒Go to IV. DRINKING after answer this question.)

- 1) Less than half a pack (1-10 cigarettes)
- 2) About one pack (11-20 cigarettes)
- 3) About one and half packs
- 4) About two packs or more

Q2. (Former smokers only) At what age did you first smoke a cigarette?

- Age of first cigarette smoking: _____ years of age

Q2-1. Before you quit smoking, how long did you smoke?

- Number of years smoked before you quit: _____ years

Q2-2. Before you quit smoking, how many cigarettes did you usually smoke per day?

- 1) Less than half a pack (1 to 10 cigarettes)
- 2) About 1 pack(11 to 20 cigarettes)
- 3) About 1 ½ packs
- 4) About 2 packs or more

Q2-3. What is the one main reason you quit smoking? (Mark only one.)

- 1) Health problems
- 2) After taking a smoking cessation program
- 3) Economic reason
- 4) Religious reason
- 5) Social atmosphere that discourages smoking
- 6) Other (_____)

Q2-4. How long have you quit smoking?

- 1) Less than 1 year
- 2) 1 year to less than 2 years
- 3) 2 years to less than 3 years
- 4) 3 years or longer
- 5) Don't know

IV. DRINKING

Q1. Do you drink alcoholic beverages?

- 1) Frequently
- 2) Occasionally
- 3) Hardly
- 4) I used to drink but not anymore
- 5) Not at all ⇒ Go to V. ORAL HEALTH

Q1-1. (Answer the following only if you drink alcohol currently.) At what age did you start drinking alcoholic beverages?

- Age of first drinking alcohol: _____ years of age

Q1-2. What is the one main reason you are currently drinking alcohol? (Mark only one.)

- 1) To relax or to relieve stress
- 2) To get along with others
- 3) Part of job
- 4) Habitual drinking
- 5) Other ()

Q1-3. Over the past 1 month, how many days did you drink alcoholic beverages, even a small amount?

- 1) None ⇒ Go to V. ORAL HEALTH
- 2) Once or less over the past 1 month
- 3) 2 to 4 times over the past 1 month
- 4) 2 to 4 times per week
- 5) Almost everyday

Q1-4. Over the past 1 month, how much do you usually drink alcoholic beverages in one drinking occasion?

- 1) 1 to 2 glasses of Soju (Less than 1 bottle of beer)
- 2) Half of 360 ml bottle of Soju (1 to 2 bottles of beer)
- 3) One 360 ml bottle of Soju (3 to 4 bottles of beer)
- 4) Two 360 ml bottles of Soju
- 5) Three 360 ml bottles of Soju or more

Q1-5. Over the past 1 month, have you experienced any issue in doing your normal activities because of the drinking on the previous day? If so, what was it and how many days for each of following? ⇒ Go to V. ORAL HEALTH after answer this question.

1) Became fully incapable of doing normal activities (taking a day off from work, school, etc.)	_____ days
2) Partially incapable of doing normal activities (Being late for work or taking hours off from work)	_____ days
3) Not being able to work as I normally do	_____ days
4) Other (_____)	_____ days

Q2. (Former drinkers only) At what age did you first drink alcoholic beverages?

■ Age of first drinking alcohol: _____ years of age

Q2-1. Before you quit drinking, how often did you usually drink alcoholic beverages?

- 1) Once or less per month
- 2) 2 to 3 times per month
- 3) 1 to 2 times per week
- 4) Almost everyday

Q2-2. How long have you been quit drinking?

- 1) Less than 1 year
- 2) 1 to less than 2 years
- 3) 2 to less than 4 years
- 4) 4 years or longer

Q2-3. What is the main reason you quit drinking alcohol?

- 1) Health problems
- 2) After taking a drinking cessation program
- 3) Economic reason
- 4) Religious reason
- 5) For fear of DUI patrol
- 6) Other (_____)

V. ORAL HEALTH

Q1. What do you usually do to maintain oral health (teeth, gum, etc.)?

- 1) Always use fluoride toothpaste.
- 2) Brush teeth longer than others do.
- 3) Refrain from smoking, drinking alcohol, etc.
- 4) Health supplements such as herbal brew, vitamins etc.
- 5) See the dentist regularly even when I have no pains.
- 6) Avoid carbonated drinks, such as Sprite, Coke, etc.
- 7) Other ()
- 8) Do nothing.

Q2. Yesterday, how many times did you brush your teeth?

- 1) Once
- 2) Twice
- 3) Three times
- 4) Four times or more

Q3. Do you see blood when you rinse your mouth after brushing your teeth?

Yes, always	Yes, more often than not	Yes, but not very often	No	Don't know
1	2	3	4	5

Q4. How would you rate your dental health compared to other people of your age?

Very poor	Poor	Fair	Good	Excellent
1	2	3	4	5

Q5. How would you rate your gum health compared to other people of your age?

Very poor	Poor	Fair	Good	Excellent
1	2	3	4	5

Q6. How much are you concerned about your dental or gum health?

Not concerned at all	Not very concerned	Moderately concerned	Sometimes concerned	Always concerned
1	2	3	4	5

VI. MAINTAINING HEALTH

Q1. Please record your height and body weight.

- Height: ____ cm
- Weight: ____ kg

Q1-1. How do you feel about your current weight?

- 1) Underweight
- 2) Within normal range
- 3) Overweight

Q1-2. Compared to 1 year ago, is there any change in your weight?

- 1) No change ⇒ Go to the Q1-3
- 2) Increased
- 3) Decreased

Q1-2-1. If your weight has changed, how much was it increased or decreased over the past 1 year?

- 1) 1kg or less
- 2) 2 to 3kg
- 3) 4 to 5kg
- 4) 6 to 7kg
- 5) 8 to 9kg
- 6) 10kg or more

Q1-3. Over the past 1 year, have you tried to lose or gain weight?

- 1) Tried to lose weight ⇒ Go to the Q1-3-1
- 2) Tried to gain weight ⇒ Go to the Q1-3-2
- 3) Never tried either way ⇒ Go to the Q2

Q1-3-1. If you have tried to lose weight, what have you mainly done? (Please list three in order.)

First		Second		Third	
-------	--	--------	--	-------	--

- 1) None
- 2) Diet
- 3) Taking special weight control supplements
- 4) Skipping meal(s)
- 5) Fasting
- 6) Taking weight loss pills
- 7) Vomiting
- 8) Taking laxatives or diuretics
- 9) Workout/exercise
- 10) Other ()

Q1-3-2. What was the main reason you tried to control your weight?

- 1) Overweight or obese
- 2) To manage high blood pressure
- 3) To manage diabetes
- 4) To manage cardiovascular disease
- 5) To maintain good health
- 6) To improve my appearance
- 7) Other ()

Q2. What do you usually do to maintain your health? (Mark only one.)

- 1) Exercise (including mountain climbing, jogging, etc.) regularly
- 2) Go on a diet
- 3) Refrain from smoking or drinking alcoholic beverages
- 4) Take herbal brew or vitamins, etc.
- 5) Take a sauna or a bath frequently
- 6) Do Ki breathing (hypogastric breathing) or Ki exercises
- 7) Other ()
- 8) Do nothing

Q3. Do you usually exercise for your health?

- 1) Yes
- 2) No ⇒ Go to the Q4

Q3-1. Do you always exercise to the point you are sweating and panting?

Yes, always	Yes, often times	Yes, but rarely	No	Don't know
1	2	3	4	5

Q3-2. How often do you usually exercise until you are sweating and panting?

- 1) Never
- 2) Occasionally (less than once per month)
- 3) Once per week
- 4) Two times per week
- 5) Three times per week
- 6) Four to five times per week
- 7) Everyday

Q3-3. For how many minutes does this exercise last in one occasion?

- 1) 14 minutes or less
- 2) 15 to 19 minutes
- 3) 20 to 20 minutes
- 4) 30 minutes or longer

Q3-4. Do you usually do this exercise at home? Or somewhere other than home or workplace?

- 1) At home
- 2) At workplace
- 3) Somewhere other than home or workplace
- 4) Other ()

Q4. Do you think your current daily exercise is not enough?

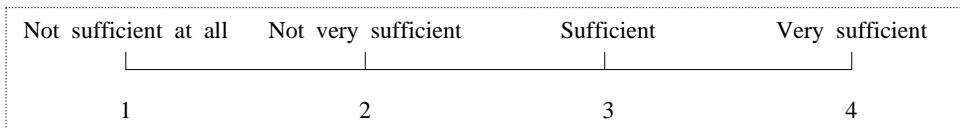
- 1) My current daily exercise is not enough
- 2) My current daily exercise is enough ⇒ Go to VII. SLEEP AND REST

Q4-1. If you think your current daily exercise is not enough, what is the reason you do not get enough exercise?

- 1) I have no time
- 2) Lack of facilities
- 3) I don't know which exercise would be best for me
- 4) Other ()

VII. SLEEP AND REST

Q1. How sufficient is your daily sleep to completely relieve previous day's fatigue?



Q1-1. If you think you are not getting enough sleep, what is the main reason for that?

- 1) Sleeping time (duration) is too short
- 2) Not getting enough sleep or quality sleep due to insomnia, etc.
- 3) Sleeping time is irregular
- 4) Other ()

Q2. How often do you feel tired?

- 1) Almost never
- 2) Occasionally
- 3) Always

Q3. How many days per week do you think you can take a rest?

- 1) Almost none
- 2) Once per week
- 3) Twice per week
- 4) Three times or more per week

Q4. How much stress do you feel in your daily life?

Never	Not very much	A little	A lot	Very much
1	2	3	4	5

Q4-1. If you ever feel stressed, where does it mainly come from?

- 1) Family life
- 2) Work life
- 3) Both family and work
- 4) Another aspect of life

Q4-2. If you ever feel stressed, what do you do to relieve stress??

- 1) Exercise
- 2) Sleep
- 3) Drinking alcoholic beverages
- 4) Watching TV or listening radio
- 5) Smoking
- 6) Hobby or leisure activities
- 7) Other ()

Q5. How would you rate your health compared to other people of your age?

Very poor	Poor	Fair	Good	Excellent
1	2	3	4	5

Q6. How often do you get concerned about your health?

Not concerned at all	Not very concerned	Moderately concerned	Frequently concerned	Always concerned
1	2	3	4	5

LASTLY, I AM GOING TO ASK YOU ABOUT YOUR CAREER AND WORK HISTORY.

1. How long have you been working in this workplace?	_____ years and _____ months
2. What is the name of the department you belong to?	
3. What are your main job duties or activities? (Please write in full detail.)	
4. How long have you been doing the duties or activities that you listed above?	_____ years and _____ months

5. If you had worked in a department other than the department you are now working in your current workplace, please write the name of the department, what were your main duties, and how long you had worked in that department.

Department	Duration	Main duties	Hazard control unit?
	About ___ years and _____ months		1) Yes 2) No
	About ___ years and _____ months		1) Yes 2) No
	About ___ years and _____ months		1) Yes 2) No

6. If you had worked in a company before you started working in the current workplace, please write the name of the previous workplace, duration of work, and main duties and activities you performed while you were there.

Name of the Company	Major Products or Services of the Company	Duration	Main duties	Hazard control unit?
		About ___ years and _____ months		1) Yes 2) No
		About ___ years and _____ months		1) Yes 2) No
		About ___ years and _____ months		1) Yes 2) No

- 1) If the name of the previous workplace is unclear, you do not have to write the exact name of it. However, please write the major products or service areas of the previous workplace as precise as possible.
- 2) Please write the major products or service areas of this company.
- 3) Under "Main Duties," please specify what kind of work you were actually did and what were your most important activities or duties while you worked there.
- 4) If the working environment of the department you worked involved handling heavy metals and chemical substance, producing dust, or was physically hazardous due to noise, vibrations, extreme heat or cold, UV rays, the department is considered as a hazard control unit.

QUESTIONS FOR DATA CLASSIFICATION

Respondent Education	1) Elementary school graduate or below 2) Middle school graduate 3) High school graduate 4) College graduate 5) Postgraduate degree
Marital Status	
Occupation	1. What is the title of your occupation?
	2. What kind of work are you doing? Please write in in full details.
	·Which work: ·With what kind of equipment or tools: ·How:
Working Hours	Average hours worked per week _____ hours/week (actual working hours including overtime work)
Employment Type	1) Full time-regular 2) General-temporary 3) Part-time/hourly 4) Dispatched worker (who is subject to the Worker Dispatch Law) 5) Subcontracted worker (whose employment is managed by the third party, like dispatched workers) 6) Other _____
Shift Work (Production Occupations only)	1) Do not work in shifts 2) Double shift 3) Triple shift 4) Hourly 5) Other

Including bonus, extra payments and other monetary incentives, what is the average amount of your annual income before tax? _____0,000 won

⇒ How would you rate your skill level and management level at your job? Skill level refers to the degree of job-related skills that you have, and management level refers to the position you might have in your workplace organization as a manager or supervisor. Please choose one from High, Middle, Low listed below.

(A) Skill Level	(B) Management Level
1. High (Professional)	1. High (Assistant director or above level manager)
2. Middle (Skilled worker)	2. Middle (Subsection chief or assistant manager level)
3. Low (Unskilled worker)\ (Not applicable if Respondent is an employer.)	3. Low (Team leader or foreman level supervisor)
	0. Not applicable (Do not manage/supervise others)