Lifestyle among urology residents and urologists. An international survey

Dear colleague

As you know, health professionals have high responsibility in patients´ care with in some cases heavy workload. In surgery, the training is rigorous and the lifestyle that accompanies a busy surgical practice is taxing, but surgery is also one of the most rewarding fields of medicine. Some studies have found high rates of depression and burnout syndrome in health professionals and residents. However, lifestyle among urologists and residents in urology is an unstudied aspect. Motivated by this, we have designed a short survey to study the lifestyle among Urology Residents and Urologists.

Your opinion and answers are very important for us. Thank you for your time and cooperation.

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* 1. Current Status:

- ◯ Urology Resident
- ◯ Urologist
- ◯ Other (please specify)

* 2. In which country do you work?

* 3. Year of Training / Practice

- 1
- 2
- 3
- 4
- 5
- ≥ 6
- Urologist (Please specify: years of practice / Researcher o Clinician)

* 4. What is your age?

- 18 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 64
- 65 to 74
- 75 or older

* 5. What is your gender?

- Male
- Female

* 6. Marital Status

- Single
- Married
- In a domestic partnership or civil union
- Divorced
- Separated
- Widowed

* 7. Do you have any children?

- ◯ No
- ◯ Yes

How many?

* 8. What is your weight in Kg?

* 9. What is your height in cm?

* 10. How many cups of coffee do you drink per day? (1=Espresso)

- ◯ None
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ > 5

* 11. How many energy drinks do you drink per week?

- ◯ None
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ > 5

* 12. How many sugary drinks (soda, fruit punch, lemonade and others) do you drink per week? (1=250ml)

- ◯ 0
- ◯ 1-5
- ◯ 5-10
- ◯ >10

* 13. How often do you drink alcohol?

- ◯ Daily
- ◯ 2-3 times per week
- ◯ Weekends
- ◯ 2-3 times a month
- ◯ I never drink alcohol

* 14. How many beers / Other alcoholic beverages do you drink per week ? (1= glass of wine/ pint of beer/ Shot)

- ◯ 0
- ◯ 1 - 5
- ◯ 5 - 10
- ◯ > 10

* 15. Are you a cigarette smoker?

- ◯ No
- ◯ I am a former cigarette smoker
- ◯ Yes, I am a cigarette smoker (How many cigarettes per day?)

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* 16. How many times per week do you eat fruit?

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ > 5

* 17. How many portions of fruit do you eat per day? (In ex 1 portion =1 apple /pear/banana/peach o 2 apricots or 3-5 strawberries,etc)

- 0
- 1
- 2
- 3
- 4
- > 5

* 18. How many times per week do you eat vegetables?

- 0
- 1
- 2
- 3
- 4
- > 5

* 19. How many portions of vegetables do you eat per day? (In ex. 1 portion= 1 carrot/ 1/2 brocoli or spinach dish, etc)

- 0
- 1
- 2
- 3
- 4
- > 5

* 20. How many times per week do you eat meat (Includes chicken, beef, pork and others)

- 0
- 1
- 2
- 3
- 4
- ≥ 5

* 21. How many times peer week do you eat fish?

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ ≥ 5

* 22. How many times per week do you eat junk food?

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ >5

* 23. How many times per week do you perform continuous exercise/sports ≥ 30 minutes)?

- ◯ 0
- ◯ 1-2
- ◯ 3 - 5
- ◯ ≥ 5

* 24. Exercise /Sport wich you perform (Multiple Choice)

- ☐ Fitness
- ☐ Running
- ☐ Swimming
- ☐ Biking
- ☐ Tennis
- ☐ Group sports (In ex. Soccer / Basketball / Rugby / handball ..etc)
- ☐ None
- ☐ Other (please specify)

* 25. Total amount of sport hours that you perform per week

- ◯ 0
- ◯ 1-3
- ◯ 3-5
- ◯ 5-7
- ◯ ≥ 7

* 26. How many hours do you sleep at night?

- ◯ ≤4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ ≥8

* 27. Do you have any of following problems when sleeping?

- ☐ Difficulty initiating sleeping
- ☐ Insomnia
- ☐ Early awakenings
- ☐ Disrupted sleep/ wake up several times at night
- ☐ No, I sleep pleasantly

* 28. Have you recently fallen asleep when you where in a situation such as: traffic stopped, driving, at the computer, on the subway or bus?

- ◯ Yes
- ◯ No

* 29. Do you use sleeping pills?

- ◯ Yes
- ◯ No

* 30. Please grade the quality of your sleep:

- ◯ Very High
- ◯ High
- ◯ Moderate
- ◯ Low
- ◯ Very Low

* 31. Has your physical health interfered with your ability to do your daily work at home?

- ◯ Yes
- ◯ No

* 32. Has your physical health/stress interfered with your ability treating patients?

- ◯ No
- ◯ Yes (please specify)

* 33. How do you perceive your health status?

- ◯ Very High
- ◯ High
- ◯ Moderate
- ◯ Low
- ◯ Very low

* 34. Please grade your satisfation with your lifestyle

- ◯ Very High
- ◯ High
- ◯ Moderate
- ◯ Low
- ◯ Very Low