## RESIDENT HEALTH SURVEY WEBSITE VERSION

Please complete the items below. This is a modified version of the annual resident health survey and is for your personal use. After you complete this, review your answers and make +s next to items you see you are doing that support your wellbeing and mark –s for items that could be improved. Then review the RWBC website topic page on Self Care Plans for guidance on how you could make changes. In particular, look at the \* items. If you scored in the concern range on any of those, please consider a consult with RWBC to help ensure those concerns don't intensity and impact your wellbeing and your success.

Below, in Questions 2-7, is a list of common feelings and attitudes that people experience. For each, mark the box corresponding to how often you have experienced or felt them <u>during the past week including today</u>.

		Never	Rarely	Sometin	nes Often	Always		
*2.	Enthusiasm about career goals.	1	2	3	4	5		
<b>*</b> 3.	Willingness to work as hard as needed to succeed	1	2	3	4	5		
4.	Feeling calm, poised, and stress-free.	1	2	3	4	5		
5.	Feeling confident with challenging patients.	1	2	3	4	5		
<b>*</b> 6.	Feeling satisfied with your progress so far in training.	1	2	3	4	5		
<b>*</b> 7.	Pleased with life overall.	1	2	3	4	5		
Hea	alth Care Services							
9.	Have you thought about being seen by a physician for	any conc	erns in th	ne past ye	ear? ¹∐Yes	$^{2}\square$ No		
10.	Have you been seen for a medical concern within the p	oast year?	<sup>1</sup> Yes	<sup>2</sup> No				
11.	Did you have a general physical exam within the past	year?	<sup>1</sup> Yes	<sup>2</sup> No				
12.	Do you have a primary care physician?		<sup>1</sup> Yes	s <sup>2</sup> No				
13.	How would you rate your health overall?	Excellent	<sup>2</sup> Goo	$d^{-3}\Box F$	air ⁴⊡Poo	r		
Life	<u>estyle</u>							
On	an average <b>DAY</b> :							
14.	How many cigarettes do you smoke per day?	¹□ N	one <sup>2</sup> [	<b>\]</b> <10	<sup>3</sup> 10-20	<sup>4</sup> >20		
15.	How many caffeinated beverages do you drink per day	y? ¹□ No	one <sup>2</sup>	]<2	<sup>3</sup> 2-3	<sup>4</sup> >3		
16.	How many hours of sleep do you get per day?	<sup>1</sup> <	5 <sup>2</sup> [		<sup>3</sup> >6			
Dur	ring an average WEEK:							
17.	How many alcoholic beverages do you drink per week	x? ¹□	None	<sup>2</sup> <2	<sup>3</sup> 2-3	<sup>4</sup> >3		
*18.How many times are you involved in a social/leisure activity in a week's time?								
<sup>1</sup> None $^2$ $^2$ $^2$ $^3$ $^2$ $^2$ $^3$ $^2$ $^3$ $^2$ $^3$ $^3$ $^2$ $^3$ $^3$ $^3$ $^4$ $^2$ $^3$ $^4$ $^3$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^3$ $^4$ $^4$ $^3$ $^4$ $^4$ $^4$ $^4$ $^3$ $^4$ $^4$ $^4$ $^4$ $^4$ $^4$ $^4$ $^4$								

$^{1}$ None $^{2}$ < 20. How many times are you involved in physical activities (exercise, sports, etc. $^{1}$ None $^{2}$ < 20. None $^{2}$ < 20.	e) in a we	eek's tin	>3 ne? >3						
*Epworth Sleepiness Scale How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.									
Use the following scale to choose the <u>most appropriate number</u> for each situation:									
0 = would <u>never</u> doze 1 = <u>slight</u> chance of dozing 2 = <u>moderate</u> chance of dozing 3 = <u>high chance</u> of dozing									
Situation	Never	Slight	Moderate	High Chance					
28. Sitting and reading	0	1	2	3					
29. Watching TV	0	1	2	3					
30. Sitting, inactive in a public place (e.g. a theatre or a meeting)	0	1	2	3					
31. As a passenger in a car for an hour without a break	0	1	2	3					
32. Lying down to rest in the afternoon when circumstances permit	0	1	2	3					
33. Sitting and talking to someone	0	1	2	3					
34. Sitting quietly after a lunch without alcohol	0	1	2	3					
35. In a car, while stopped for a few minutes in traffic	0	1	2	3					
*Total Score 10 or higher	Total:								
Mentoring									
Formal Mentors									
36. Do you have a mentor?yesno									
37. In the past year how many times did you talked with your mentor: (give a number):									
38. Which of the following did your program do: (check all that apply) assign new residents to a mentor encourage, but not assign, residents to have a mentor  confirm with you that you had your first meeting with your mentor									

## **Informal Mentoring**

\*Total Score 10 or higher

A survey of residents found that they want three things in mentoring:

- career advice such as post residency choices, research options, exploration of 'the big picture'
- -<u>support</u> including confidential support, being open to any type of question and discussion of current stresses, listening to ideas, facilitate networking and providing a sounding board
- *role modeling* that offers encouragement and inspiration, advice on career-personal life balance, real-life perspective, demonstrating light at the end of the training tunnel, offering examples of successes and managing difficulties

Informal mentoring can occur in your interactions with attendings, faculty, chiefs, seniors, program directors and your peers and others. If it involves any of the three elements of mentoring described above, it can be considered mentoring. Please consider this as you answer the next few questions. \_\_\_\_Yes \_\_\_ No 39. Have you received informal mentoring in residency? 40. Have you received informal mentoring from more than one person? \_\_\_\_\_Yes \_\_\_\_\_No 41. In the past year overall how often do you think you received informal mentoring (mark only one below): \_\_\_\_several times per day \_\_\_\_daily \_\_\_\_several times per week \_\_\_\_once a week \_\_\_\_less than once a wk **Feedback** 42. Which of the following has occurred for you during residency: (mark only those that occurred for you) been taught how to ask for and receive feedback encouraged to ask for feeback been asked about the quality of the feedback you receive \_\_\_\_been asked about the timeliness of the feedback you receive \*PHO-9 Over the *last 2 weeks*, how often have you been bothered by any of the following problems? (circle the number to indicate your answer): **Not at all** Several days More than half Nearly all the days the days **1.** Little interest or pleasure in doing things 0 1 2 3 **2.** Feeling down, depressed, or hopeless 0 1 3 2 0 1 3 **3.** Trouble falling or staying asleep, or sleeping too much **4.** Feeling tired or having little energy 0 1 3 2 3 **5.** Poor appetite or overeating 0 1 **6.** Feeling bad about yourself—or that 0 1 2 3 you are a failure or have let yourself or your family down 7. Trouble concentrating on things, 0 1 2 3 such as reading the newspaper or watching television **8.** Moving or speaking so slowly that 0 1 2 3 other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual \*9. Thoughts that you would be better off dead, 0 1 2 3 or of hurting yourself in some way

Total: