

## GB05 Initial hand-arm vibration screening questionnaire

### Medical in confidence - when completed

Initial screening questionnaire for workers using hand-held vibrating tools, hand-guided vibrating machines and hand-fed vibrating machines.

|  |     |                          |                             |
|--|-----|--------------------------|-----------------------------|
| <b>Company name</b>  |     | <b>Project title</b>     |                             |
| <b>Location</b>  |     | <b>Contract no.</b>      |                             |
| <b>Date</b>  |     |                          |                             |
| <b>Employee name</b>   |     |                          |                             |
| <b>Occupation</b>  |     |                          |                             |
| <b>Address</b>   |     |                          |                             |
| <b>Date of birth</b>   |     |                          |                             |
| <b>Employer name</b>   |     |                          |                             |
| <b>1. Have you ever used hand-held vibrating tools, machines or hand-fed processes in your job?</b>                            | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| <b>If 'Yes':</b>   |     |                          |                             |
| <b>a) give year of first exposure</b>  |     |                          |                             |
| <b>b) when was the last time you used them?</b><br><i>(detail work history overleaf)</i>                                       |     |                          |                             |
| <b>2. Do your fingers tingle for more than 20 minutes after using vibrating equipment?</b>                                     | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| <b>3. Do your fingers tingle at any other time?</b>  | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| <b>4. Do you wake at night with pain, tingling or numbness in your hand or wrist?</b>  | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| <b>5. Are one or more of your fingers numb for more than 20 minutes after using vibrating equipment?</b>                       | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| <b>6. Have your fingers gone white* on cold exposure?</b>  | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| <b>If 'Yes', do you have difficulty warming them up again when leaving the cold?</b>   | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| <b>7. Do your fingers go white at any other time?</b>  | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| <b>8. Are you experiencing any other problems with the muscles or joints of your hands or arms?</b>                            | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| <b>9. Do you have difficulty picking up small objects (for example, screws or buttons) or opening tight jars?</b>              | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| <b>10. Have you ever had a neck, arm or hand injury or operation? If 'Yes' give details below</b>                              | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
|  |     |                          |                             |
| <b>11. Have you ever had any serious diseases of joints, skin, nerves, heart or blood vessels? If 'Yes' give details below</b> | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
|  |     |                          |                             |
| <b>12. Are you on any long-term medication? If 'Yes' give details below</b>  | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
|  |     |                          |                             |
| <small>*Whiteness means a clear discolouration of the fingers with a sharp edge, usually followed by a red flush</small>       |     |                          |                             |

