**INITIAL SCREENING QUESTIONNAIRE FOR WORKERS USING HAND-HELD VIBRATING TOOLS, HAND-GUIDED VIBRATING MACHINES AND HAND-FED VIBRATING MACHINES**

Date:.........................................................................................................................

Employee name:........................................................................................................

Occupation:...............................................................................................................

Address:.....................................................................................................................

Date of birth:..............................................................................................................

National Insurance no:...............................................................................................

Employer name:........................................................................................................

**Have you ever used hand-held vibrating tools, machines or hand-fed**

**processes in your job?**

**If YES:**

1. **list year of first exposure ................................................................................**

**(b) when was the last time you used them?........................................................**

(detail work history overleaf)

1 Do you have any tingling of the fingers lasting more than 20 minutes

after using vibrating equipment?

2 Do you have tingling of the fingers at any other time?

3 Do you wake at night with pain, tingling, or numbness in your hand

or wrist?

4 Do one or more of your fingers go numb more than 20 minutes after

using vibrating equipment?

5 Have your fingers gone white\* on cold exposure?

*\* Whiteness means a clear discoloration of the fingers with a sharp edge, usually followed by a red flush.*

*Blanching*



6 If Yes to 5, do you have difficulty rewarming them when leaving the cold?

7 Do your fingers go white at any other time?

8 Are you experiencing any other problems with the muscles or joints of

the hands or arms?

9 Do you have difficulty picking up very small objects, eg screws or buttons

or opening tight jars?

10 Have you ever had a neck, arm or hand injury or operation?

If so give details................................................................................

11 Have you ever had any serious diseases of joints, skin, nerves, heart or blood vessels?

If so give details................................................................................

12 Are you on any long-term medication?

If so give details................................................................................

**OCCUPATIONAL HISTORY**

**Dates Job Title**

**……………………………………………………………………………………………...**

**……………………………………………………………………………………………...**

**……………………………………………………………………………………………...**

**……………………………………………………………………………………………...**

**……………………………………………………………………………………………...**

**……………………………………………………………………………………………...**

**………………………………………………………………………………………………**

**……………………………………………………………………………………………...**

**………………………………………………………………………………………………**

**I certify that all the answers given above are true to the best of my knowledge and belief.**

**Signed: Date:**

**RETURN IN CONFIDENCE TO:**

**.................................................................................................................................**