

Appendix 4

Clinical questionnaire

**MEDICAL IN CONFIDENCE
HEALTH SURVEILLANCE QUESTIONNAIRE**

ASSESSMENT OF HAND-ARM VIBRATION SYNDROME

Date:

Mr/Mrs/Miss/Ms SURNAMEFORENAMES

ADDRESS.....

..... POST CODE

DATE OF BIRTH

ETHNIC GROUP:

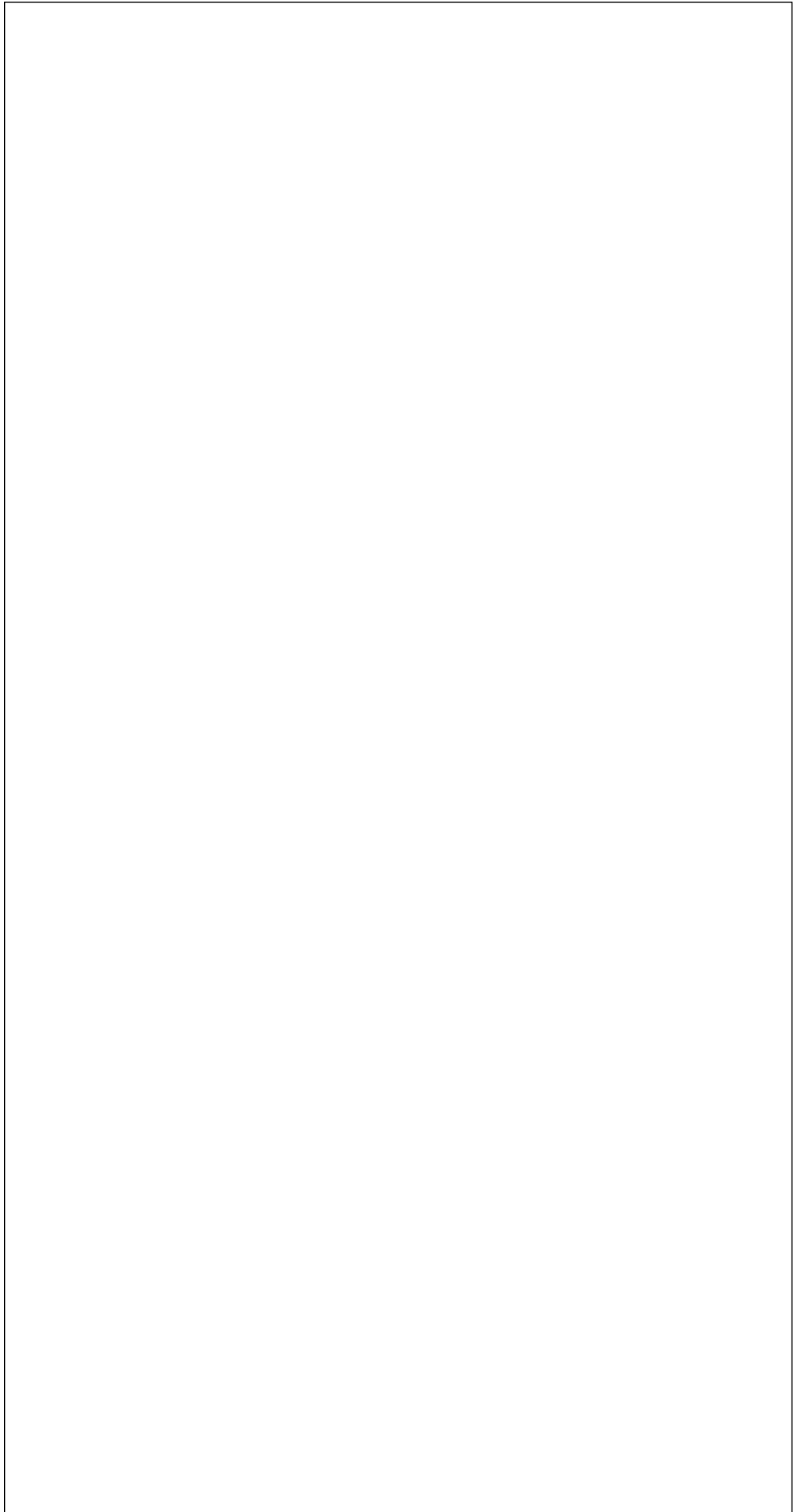
European Afro Caribbean Asian Other

OCCUPATION EMPLOYER

GENERAL PRACTITIONER ADDRESS.....

.....

Free text area to ask general questions about the person's work and symptoms



HAND SYMPTOMS

Blanching

Have you ever suffered from your fingers going white?
If No go to the section on Tingling symptoms.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If yes (and still occurring in the last 2 years) does it occur:
In response to cold, damp or wet conditions?
While working?
At other times?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Please give examples

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.....

.....

.....

.....

When did you first notice this whiteness?

Year

How often does it occur?
Several times a year
Several times a month
Several times a day
Every day
Does it occur in winter only
Winter and summer

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

State most common circumstances

.....

.....

Do you experience whiteness in your feet or other periphery?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If yes state where.....

Which fingers are affected? (shade all parts that have ever gone white)

Right hand

Left hand



Witnessed Not witnessed by person completing screening

Tingling (excluding transient tingling lasting for up to 20 minutes after using vibrating tools)

Do you have tingling of the fingers?
 In response to cold?
 With blanching?
 While working?
 At other times?

Yes	No

If other times, what circumstances, and how long does it last?

.....

.....

.....

When did you first notice this?..... Year

Which fingers are affected? (shade all affected parts)

Right hand



Left hand



Numbness (excluding transient tingling lasting for up to 20 minutes after using vibrating tools)

Do your fingers go numb?
 In response to cold?
 With blanching?
 While working?
 At other times?

Yes	No

If other times, what circumstances, and how long does it last?

.....

.....

.....

When did you first notice this?..... Year

Right hand



Left hand



Yes No

Do you have any difficulty handling or manipulating small objects?

If yes when does this occur?.....

Yes No

Do any of these symptoms (blanching, tingling or numbness) affect your work or leisure activities?

If yes, give details

.....

.....

Musculoskeletal

Yes No

Are you experiencing problems with the muscles or joints of your hands/arms/wrists/elbows/shoulders?

Pain
Stiffness
Swelling
Weakness

Yes No

If yes, give details

.....

.....

OCCUPATIONAL HISTORY

Right handed Left handed Leading hand: Right Left

When did you first start using vibrating tools or equipment?.....

Where do you notice the vibration most?

If you no longer use vibrating tools when did you stop?.....

Which of the main elements of your present job involve use of vibrating tools or equipment and how much time per day ('trigger' or contact time)?

	Hours/Day	Days/Week
(a)	<input type="checkbox"/>	<input type="checkbox"/>
(b)	<input type="checkbox"/>	<input type="checkbox"/>
(c)	<input type="checkbox"/>	<input type="checkbox"/>
(d)	<input type="checkbox"/>	<input type="checkbox"/>

When did you join the company?

List main jobs and departments in order:	Hours/Day	Years
(a)	<input type="text"/>	<input type="text"/>
(b)	<input type="text"/>	<input type="text"/>
(c)	<input type="text"/>	<input type="text"/>
(d)	<input type="text"/>	<input type="text"/>

What jobs did you do previously, outside this company, involving vibration?

(a)	<input type="text"/>	<input type="text"/>
(b)	<input type="text"/>	<input type="text"/>
(c)	<input type="text"/>	<input type="text"/>
(d)	<input type="text"/>	<input type="text"/>

Yes **No**

Have you had any exposure to chemicals at work?

If yes, give details

.....
.....

SOCIAL HISTORY/ LEISURE PURSUITS

Yes **No**

Do any of your hobbies expose you to hand-arm vibration?

If yes, give details

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.....

Are you a smoker? Non-smoker? Ex-smoker?

If smoker, how many do you smoke each day?/day

If ex-smoker, when did you stop?

Do you drink alcohol?

If yes, how many units per week?units/week

MEDICAL HISTORY

Do other members of your family suffer from white finger? (brothers, sisters and parents only) Yes No

If so, who?

Have you ever had a neck/arm/hand injury or operation? Yes No

If so, what and when?

Were you left with any problems? Yes No

If so, what?

Have you ever had any serious disease of:

	Yes	No
Joints?		
Skin?		
Nerves?		
Heart or blood vessels?		
Other?		

If so, give details
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Are you on any long-term medication or treatment for any condition: Yes No

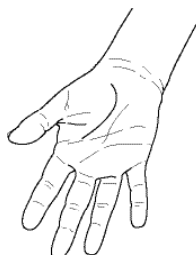
If so, give details?
.....
.....

EXAMINATION

(Note last exposure to vibration) Room temperature °C

Appearance of hands Note any signs of vascular disease, deformity, scars, callosities or muscle wasting.

Right hand



Left hand



Circulation

Pulse rate (bpm)
Lying/sitting

Blood pressure (mm Hg)

Right	<input type="text"/>
Left	<input type="text"/>

Right	<input type="text"/>
Left	<input type="text"/>

		Present	Absent			Present	Absent
Radial pulse	Rt	<input type="text"/>	<input type="text"/>	Lt	<input type="text"/>	<input type="text"/>	
Ulnar pulse	Rt	<input type="text"/>	<input type="text"/>	Lt	<input type="text"/>	<input type="text"/>	

		Positive	Negative			Positive	Negative
Allen's test	Rt	<input type="text"/>	<input type="text"/>	Lt	<input type="text"/>	<input type="text"/>	

Nervous System

		Normal	Abnormal			Normal	Abnormal
Semmes-Weinstein	Rt	<input type="text"/>	<input type="text"/>	Lt	<input type="text"/>	<input type="text"/>	
Manual dexterity (Purdue Pegboard test)	Rt	<input type="text"/>	<input type="text"/>	Lt	<input type="text"/>	<input type="text"/>	

Further tests, where appropriate

Adson's test	Rt	<input type="text"/>	<input type="text"/>	Lt	<input type="text"/>	<input type="text"/>
Tinel's test	Rt	<input type="text"/>	<input type="text"/>	Lt	<input type="text"/>	<input type="text"/>
Phalen's test	Rt	<input type="text"/>	<input type="text"/>	Lt	<input type="text"/>	<input type="text"/>

Musculoskeletal

Describe any abnormality of neck or upper limbs

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	Rt				Lt			
Grip strength (in kg)	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	
Average	<input type="text"/>							

ASSESSMENT OF HISTORY AND EXAMINATION

Vascular

	Yes	No
Primary Raynaud's phenomenon present?	<input type="text"/>	<input type="text"/>
Secondary Raynaud's phenomenon present?	<input type="text"/>	<input type="text"/>
If so, is this vibration induced?	<input type="text"/>	<input type="text"/>

	Right	Left
Stockholm Vascular grading	<input type="text"/>	<input type="text"/>

Neurological

Neurological impairment suggested by clinical assessment?

Right Left

Stockholm Sensorineural grading

<input type="text"/>	<input type="text"/>
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Yes No

Is carpal tunnel syndrome suggested by history and findings?

<input type="text"/>	<input type="text"/>
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Musculoskeletal

Yes No

Muscular or soft tissue disorder present?

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Evidence of skeletal disorder

Latent periods

Years

Vascular

Neurological

Musculoskeletal

Yes No

Further special investigations required?

<input type="text"/>	<input type="text"/>
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Results

Vibrotactile Threshold Rt Lt

Temperature Threshold Rt Lt

Yes No

Fit for work with exposure to hand-transmitted vibration?

<input type="text"/>	<input type="text"/>
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Any conditions or vibration restrictions to be followed?.....

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Yes No

Has advisory leaflet been received by employee?

<input type="text"/>	<input type="text"/>
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Comments on overall assessment

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Date for next medical review.....

Signature:

Nursing/Medical Officer