

Appendix 2

Initial screening questionnaire

MEDICAL IN CONFIDENCE

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? Y/N

If YES:

(a) 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? Y/N

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

3 Do you wake at night with pain, tingling, or numbness in your hand or wrist? Y/N

4 Do one or more of your fingers go numb more than 20 minutes after using vibrating equipment? Y/N

5 Have your fingers gone white* on cold exposure? Y/N

**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? Y/N

7 Do your fingers go white at any other time? Y/N

8 Are you experiencing any other problems with the muscles or joints of the hands or arms? Y/N

9 Do you have difficulty picking up very small objects, eg screws or buttons or opening tight jars? Y/N

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

If so give details.....

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

If so give details.....

12 Are you on any long-term medication? Y/N

If so give details.....

OCCUPATIONAL HISTORY

Dates

Job Title

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

Signed:

Date:

RETURN IN CONFIDENCE TO:

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