





**HAVSRM Hand Arm Vibration Medical Questionnaire**  
 (To Determine Referral to Medical Practitioner for Further Assessment)



<b>PERSONNEL DETAILS</b>		
Name		Date of Birth
Address		Occupation
		Department
Tel:		
Doctors Name		Next of Kin
Doctors Address		Next of Kin Address
Tel:		Tel:
<b>EMPLOYMENT HISTORY (last ten years)</b>		
1. Employer		Tools & Vibrating Equipment Used During Employment
Employed From	Employed To	
2. Employer		Tools & Vibrating Equipment Used During Employment
Employed From	Employed To	
3. Employer		Tools & Vibrating Equipment Used During Employment
Employed From	Employed To	
4. Employer		Tools & Vibrating Equipment Used During Employment
Employed From	Employed To	

<b>POTENTIAL SYMPTONS OF HAVS</b>	
Do your or have your fingers go/gone white whilst you are working?  <b>Yes/No</b>	Does this happen in the winter only?  <b>Yes/No</b>
How long did it/does it last for?	When did this first come to your attention?
<b>PLEASE SHADE THE EFFECTED AREA ON THE HANDS BELOW</b>	
<b>LEFT HAND</b> 	<b>RIGHT HAND</b> 
Do your or have your fingers tingle/d whilst you are working?  <b>Yes/No</b>	Does this happen in the winter only?  <b>Yes/No</b>
How long did it/does it last for?	When did this first come to your attention?
<b>PLEASE SHADE THE EFFECTED AREA ON THE HANDS BELOW</b>	
<b>LEFT HAND</b> 	<b>RIGHT HAND</b> 
Do you have any difficulty with muscles or joints in your hands?  <b>Yes/No</b>	Do you have any medical history that may affect your hands or arms?  <b>Yes/No</b>

Are you being treated by a doctor for any illness?  <b>Yes/No</b>	Are you currently taking any medication?  <b>Yes/No</b>
How many cigarettes a day do you smoke?	How many units of alcohol do you drink a week (1 unit = one glass of wine or ½ pint of beer or a single short)
<b>OUTSIDE WORKING HOURS</b>	
Do you carry out any part time jobs or voluntary work outside your main employment duties?  <b>Yes/No</b>	Please list any current or previous hobbies, leisure activities.
<b>PLEASE USE THIS SPACE TO LIST ANY COMMENTS OR OTHER INFORMATION YOU THINK MAY BE USEFUL TO THIS ASSESSMENT</b>	
Have you ever undertaken a medical assessment for employment or insurance purposes?  <b>Yes/No</b>	Have you ever been diagnosed as having any symptoms of Hand Vibration Syndrome?  <b>Yes/No</b>
<b>Signed</b>	<b>Dated</b>
For Internal Use	

Thank you for completing this questionnaire your co-operation is greatly appreciated. The information you have provided will be used to help with the prevention and early detection of Hand Arm Vibration Syndrome (HAVS).

**If you think you may be developing any symptom of Hand Arm Vibration Syndrome you must STOP working with vibrating tools and inform your supervisor IMMEDIATELY.**