HAVS short screening questionnaire

to be completed by a health professional

Surname
Forenames

M / F

DOB
NI / clock No.

Grade/job

Business
Location

Manager
Contact no.

Details of exposure

The previous medical and occupational history have been recorded on (date):
NB must include details of previous vibration exposure

Which tools are used?

1. □ 2. □
3. □ 4. □
5. □ 6. □
7. □ 8. □
9. □ 10. □

Other (specify)

Dominant hand
Right / Left / Both

Leading hand
Right / Left / Both

Average time and pattern of exposure

Brief details of risk assessment and control measures, including training.

Relevant hobbies

Continue overleaf……
Screening Questions

Questions 1 to 6 – every attendance

1. Have you ever suffered from your fingers going white? YES □ NO □

2. Do you notice tingling of your fingers, except during or just after using vibrating tools? YES □ NO □

3. Do your fingers go numb? YES □ NO □

4. Do you have trouble with the muscles or joints in your hands or arms? YES □ NO □

5. Is your grip noticeably weaker than it used to be? YES □ NO □

6. Do you have trouble handling small objects like buttons or coins? YES □ NO □

Questions 7 to 10 – first attendance only.

7. Have you ever been told that you suffer from ‘White Finger’ (hand-arm vibration syndrome)? YES □ NO □

8. Have you worked with people who suffered from White Finger? YES □ NO □

9. Have you ever been told that you suffer from Raynaud’s disease or phenomenon? YES □ NO □

10. Do other members of your family suffer from White Finger or Raynaud’s? YES □ NO □

IF SUBJECT ANSWERS YES TO ANY OF QUESTIONS 1-10 GO ON TO HAVS LONG QUESTIONNAIRE AND DISCUSS WITH OCCUPATIONAL PHYSICIAN

Comments

Outcome

Subject reminded to report any hand / arm symptoms YES □

Subject given information about HAVS YES □

Fit to continue with current job and exposure YES □ SEE LONG QUESTIONNAIRE □

Name of assessor

Date of assessment

Signature