Appendix 4

Clinical questionnaire

MEDICAL IN CONFIDENCE
HEALTH SURVEILLANCE QUESTIONNAIRE

ASSESSMENT OF HAND-ARM VIBRATION SYNDROME

Date: | | | |

Mr/Mrs/Miss/Ms SURNAME ……………………FORENAMES …………………..

ADDRESS………………………………………………………………………………

……………………………………………………. POST CODE …………………....

DATE OF BIRTH | | | |

ETHNIC GROUP:

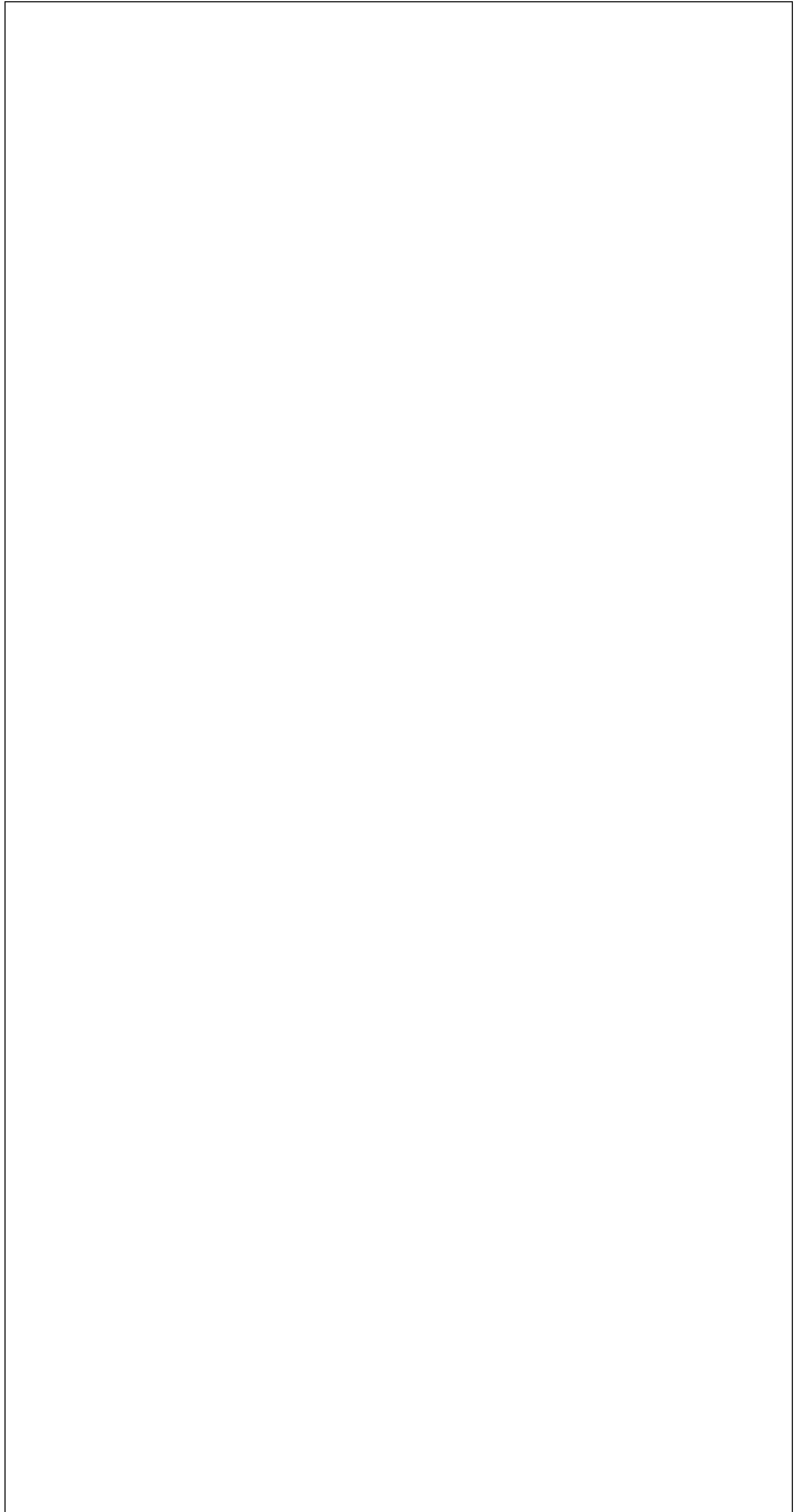
European [ ] Afro Caribbean [ ] Asian [ ] Other [ ]

OCCUPATION ………………………….. EMPLOYER …………………………….....

GENERAL PRACTITIONER ADDRESS………..

.............................………………………………………………………………

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



HAND SYMPTOMS

Blanching

	Yes	No
Have you ever suffered from your fingers going white?		

If No go to the section on Tingling symptoms.

If yes (and still occurring in the last 2 years) does it occur:	Yes	No
In response to cold, damp or wet conditions?		
While working?		
At other times?		

Please give examples

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

How often does it occur?	Yes	No
Several times a year		
Several times a month		
Several times a day		
Every day		
Does it occur in winter only		
Winter and summer		

State most common circumstances

....

....

	Yes	No
Do you experience whiteness in your feet or other periphery?		

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
In response to cold?		
With blanching?		
While working?		
At other times?		

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

……………………………………………………………………………………………

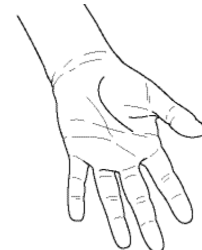
……………………………………………………………………………………………

……………………………………………………………………………………………

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
In response to cold?		
With blanching?		
While working?		
At other times?		

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

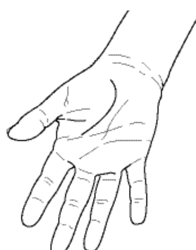
……………………………………………………………………………………………

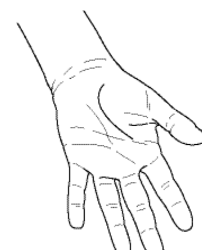
……………………………………………………………………………………………

……………………………………………………………………………………………

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?		

	Yes	No
Pain		
Stiffness		
Swelling		
Weakness		

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)		
(b)		
(c)		
(d)		

When did you join the company? ………………………………………………………………

List main jobs and departments in order:	Hours/Day	Years
(a) ………………………………………………	☐	☐
(b) ………………………………………………	☐	☐
(c) ………………………………………………	☐	☐
(d) ………………………………………………	☐	☐

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

(a) ………………………………………………	☐	☐
(b) ………………………………………………	☐	☐
(c) ………………………………………………	☐	☐
(d) ………………………………………………	☐	☐

	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

…………………………………………………………………………………………………

…………………………………………………………………………………………………

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

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

If so, who? ……………………………………….

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

If so, what and when? …………………………………………………………..

	Yes	No
Were you left with any problems?		

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

……………………………………………………………………………………………

……………………………………………………………………………………………

	Yes	No
Are you on any long-term medication or treatment for any condition:		

If so, give details?

……………………………………………………………………………………………

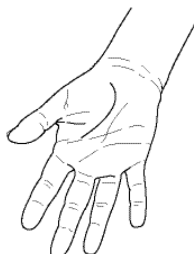
……………………………………………………………………………………………

EXAMINATION

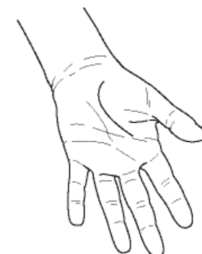
(Note last exposure to vibration) Room temperature °C [ ]

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		Right	
Left		Left	

		Present	Absent		Present	Absent
Radial pulse	Rt			Lt		
Ulnar pulse	Rt			Lt		

		Positive	Negative		Positive	Negative
Allen's test	Rt			Lt		

Nervous System

		Normal	Abnormal		Normal	Abnormal
Semmes-Weinstein	Rt			Lt		
Manual dexterity (Purdue Pegboard test)	Rt			Lt		

Further tests, where appropriate

Adson's test	Rt			Lt		
Tinel's test	Rt			Lt		
Phalen's test	Rt			Lt		

Musculoskeletal

Describe any abnormality of neck or upper limbs …………………………………..

……………………………………………………………………………………………..

	Rt			Lt		
Grip strength (in kg)						
Average						

ASSESSMENT OF HISTORY AND EXAMINATION

Vascular

	Yes	**No**
Primary Raynaud's phenomenon present?		
Secondary Raynaud's phenomenon present?		
If so, is this vibration induced?		

	Right	Left
Stockholm Vascular grading		

Neurological

Neurological impairment suggested by clinical assessment?

	Right	Left
Stockholm Sensorineural grading		

	Yes	No
Is carpal tunnel syndrome suggested by history and findings?		

Musculoskeletal

	Yes	No
Muscular or soft tissue disorder present?		
Evidence of skeletal disorder		

Latent periods	Years
Vascular	
Neurological	
Musculoskeletal	

	Yes	No
Further special investigations required?		

Results

Vibrotactile Threshold Rt Lt

Temperature Threshold Rt Lt

	Yes	No
Fit for work with exposure to hand-transmitted vibration?		

Any conditions or vibration restrictions to be followed?..

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	Yes	No
Has advisory leaflet been received by employee?		

Comments on overall assessment

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Date for next medical review..

Signature: ....
Nursing/Medical Officer