Medical in Confidence

Initial HAVS Health Surveillance Questionnaire (Tier 1)

NAME: ……………………………………………………… D.O.B.: ……………………………………………………………..

EMPLOYEE NUMBER ……………………………………. LOCATION ……………………………………………………………

EMPLOYER: ………………………………………………. JOB TITLE: ……………………………..…………………………

ADDRESS: ………………………………………………… TEL NO: ……………………………..…………………………..

………………………………………………………………….. SERVICE ………………………..………………...…………………

LINE MANAGER …………………………………………… LINE MANAGER email address …………………………….…………

This form is to be completed by those individuals who will be required to use hand held vibrating tools (including hand guided vibrating machines and handfed vibrating machines) as part of their work.

Occupational Health will use this information to provide guidance to your employer on your fitness to work with hand held vibrating tools. You may need to attend for a more detailed medical assessment.

Please read the accompanying leaflet 'Hand-Arm Vibration Advice for Employees' before completing this form.

	Yes	No	**Details & Dates** (Give full information where applicable)
1. Will you use handheld vibrating tools in your job?	☐	☐	…………………………………………………………
2. Do you have any tingling of the fingers lasting more than 20 minutes after using vibrating equipment?	☐	☐	…………………………………………………………
3. Do you have tingling of the fingers at any other time?	☐	☐	…………………………………………………………
4. Do you wake at night with pain, tingling, or numbness in your hand or wrist?	☐	☐	…………………………………………………………
5. Do one or more of your fingers go numb more than 20 minutes after using vibrating equipment?	☐	☐	…………………………………………………………
6. Have your fingers gone white* on cold exposure? (*Whiteness means a clear discoloration of the fingers with a sharp edge, usually followed by red flush. See attached photograph of blanching – Figure 1).	☐	☐	…………………………………………………………
7. If YES to Question 5, do you have difficulty rewarming your fingers when leaving the cold?	☐	☐	…………………………………………………………
8. Do your fingers go white at any other time?	☐	☐	…………………………………………………………
9. Are you experiencing other problems with the muscles or joints of your hands or arms?	☐	☐	…………………………………………………………
10. Do you have difficulty picking up very small objects eg. screws or buttons or opening tight jars?	☐	☐	…………………………………………………………
11. Have you ever had a neck, arm or hand injury or operation?	☐	☐	…………………………………………………………
12. Have you ever had any serious disease of joints, skin, nerves, heart or blood vessels?	☐	☐	…………………………………………………………
13. Are you taking any long-term medication?	☐	☐	…………………………………………………………

	Yes	No	Details & Dates (Give full information where applicable)
14. Have you used handheld vibrating tools in any previous employment? If yes, provide details including dates.	☐	☐	…………………………………………………………

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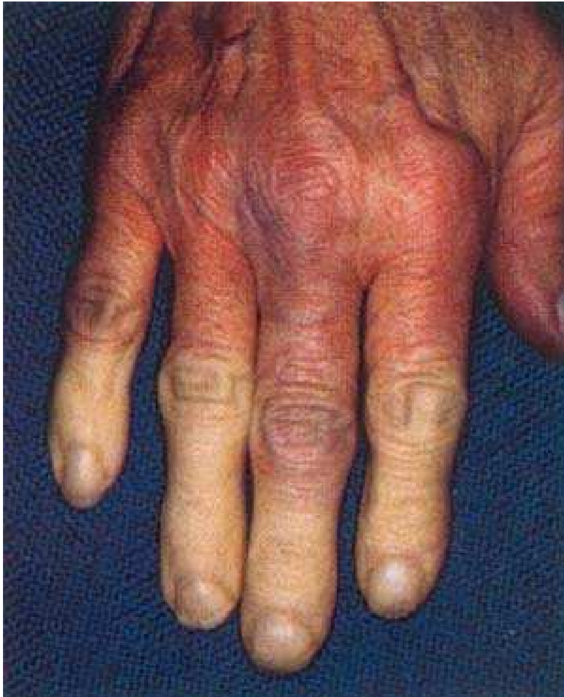
I certify that all the answers given are true to the best of my knowledge and belief.

Signed: ………………………………………………… Date: ……………………………………..

Return in the envelope marked Strictly Private & Confidential.

Figure 1:



Occupational Health use only (delete as appropriate)

Outcome Fit without restrictions / Tier 3 Assessment recommended

Recommended Annual Review Tier 2 / Tier 3

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Name: ………………………………….. Signature: ……………………………………… Date: ………………………………………..