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

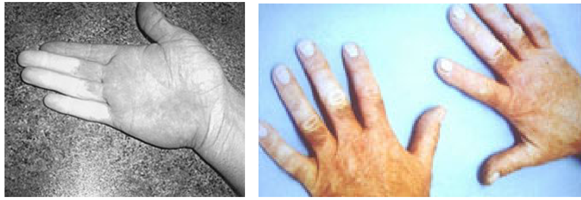
Continue overleaf……

 ©Occupational Health Solutions Ltd

Screening Questions

Questions 1 to 6 – every attendance

		YES	NO
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?	☐	☐
3	Do your fingers go numb?	☐	☐
4	Do you have trouble with the muscles or joints in your hands or arms?	☐	☐
5	Is your grip noticeably weaker than it used to be?	☐	☐
6	Do you have trouble handling small objects like buttons or coins?	☐	☐

Questions 7 to 10 – first attendance only.

		YES	NO
7	Have you ever been told that you suffer from 'White Finger' (hand-arm vibration syndrome)?	☐	☐
8	Have you worked with people who suffered from White Finger?	☐	☐
9	Have you ever been told that you suffer from Raynaud's disease or phenomenon?	☐	☐
10	Do other members of your family suffer from White Finger or Raynaud's?	☐	☐

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	