



SKIN QUESTIONNAIRE

Please complete and bring this questionnaire with you to your appointment:

Surname:	Frist Name	Date of Skin Assessment:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Company:	Date employment started:	Job Title:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address:	What does your job involve:	
<input type="text"/>	<input type="text"/>	
Contact Telephone Number:	Date of Birth:	
<input type="text"/>	<input type="text"/>	

OCCUPATIONAL HISTORY

DETAILS HERE PLEASE

List companies previously worked for and type of work involved	<input type="text"/>
Describe your present work activities	<input type="text"/>
Give details of materials/substances that you work with	<input type="text"/>
Give details of hobbies	<input type="text"/>
Give details of any known allergies	<input type="text"/>
Do you have a history of skin problems Yes <input type="checkbox"/> No <input type="checkbox"/> If yes please give details	<input type="text"/>
What Personal Protective Equipment & Clothing do you currently use?	<input type="text"/>
Do you use barrier cream? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>
Name of Barrier cream	<input type="text"/>



HAND ARM VIBRATION ASSESSMENT QUESTIONNAIRE

HEALTH ASSESSMENT

In the last 6 months have you had any of the following symptoms?

DETAILS HERE PLEASE

- a) Redness and swelling of fingers and hands? Yes No
- b) Cracking or splitting of skin on fingers or hands? Yes No
- c) Blisters on fingers or hands? Yes No
- d) Flaking or scaling of skin on fingers or hands? Yes No
- e) Itching of fingers or hands? Yes No
- f) Redness or Itchiness of any other part of your skin? Yes No

Did these problems last for more than 3 weeks? Yes No

Did these problems occur more than once? Yes No

Does your skin get better with periods off work? Yes No

Have you lost time from work with skin problems? Yes No

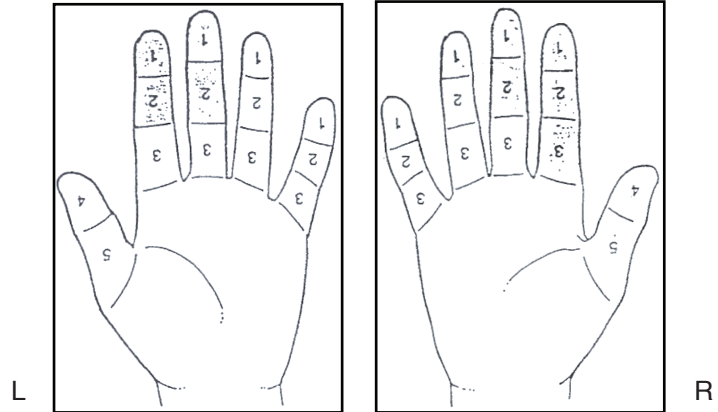
Are you currently taking any medication?
(Including therapeutic skin creams) Yes No

If you are having symptoms, do you think you know what causes the problem? If so what?

Name the substance/material/contact you think may be responsible

HAND ARM VIBRATION ASSESSMENT QUESTIONNAIRE

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CLINICAL EXAMINATION



FINDINGS/ACTIONS/RECOMMENDATIONS

TICK

Dryness / Redness / Itchiness/ Combination of 2 of these	Advise use of Emollient/Barrier cream Review work practices Review use of PPE/PPC	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cracking, bleeding or significant blistering	Remove from Task Refer to GP/OHP Review work practice Review Risk Assessment Review work practice Review use of PPE/PPC	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hands in good condition		<input type="checkbox"/>
Good Handcare Regime followed		<input type="checkbox"/>
PPP as per risk assessment worn		<input type="checkbox"/>

Adjustments/ Further Advice given

RESULTS

Fit / Fit with Adjustments / Unfit Yes No

Referral to GP: Yes No

Referral to Occupational Health Physician: Yes No Date of next review

OH Signature: Henri Vale Date

Employee Declaration

I declare that the information given in this document is true and complete to the best of my knowledge, and that I understand that failure to disclose information may affect my employment.

I consent to undertaking a skin assessment and the results being submitted and discussed with my company management, with a report being sent by the Occupational Health provider to my GP if necessary.

Signature: _____ **Date:** _____