



HAND ARM VIBRATION ASSESSMENT QUESTIONNAIRE

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

Surname:	First Name	Company:
<input type="text"/>	<input type="text"/>	<input type="text"/>
HAVS Screen date:	Date of Birth:	Male / Female:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Job Title:	<input type="text"/>	Date commenced current job?
<input type="text"/>		<input type="text"/>
What was your previous occupation?	<input type="text"/>	
Name of previous employer(s)	<input type="text"/>	

CURRENT WORK

Describe your job and its different tasks

Write below each Power Driven tool you use:

List All Equipment Used

Use of each tool in
Tick Minutes or Hours per Day

<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>

MEDICAL HISTORY

Are you a smoker ☐ Are you a non-smoker ☐ Are you a ex-smoker ☐

If an ex-smoker, when did you stop?

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

If so what and when?

Are there any residual symptoms or deformities? Yes ☐ No ☐

Have you ever had any serious disease of the:

Joints	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Skin	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Nerves	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart/blood vessels	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If so give details:

HAND ARM VIBRATION ASSESSMENT QUESTIONNAIRE

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

If so what and when?

HAND SYMPTOMS

Have you every suffered from your fingers going white on exposure to cold? Yes ☐ No ☐

If yes, is it continuous ☐ episodic ☐ When did you first notice this?

If you suffer now, how often does it occur?

Several times a year? Yes ☐ No ☐

Several times a month? Yes ☐ No ☐

Several times a day? Yes ☐ No ☐

Every day? Yes ☐ No ☐

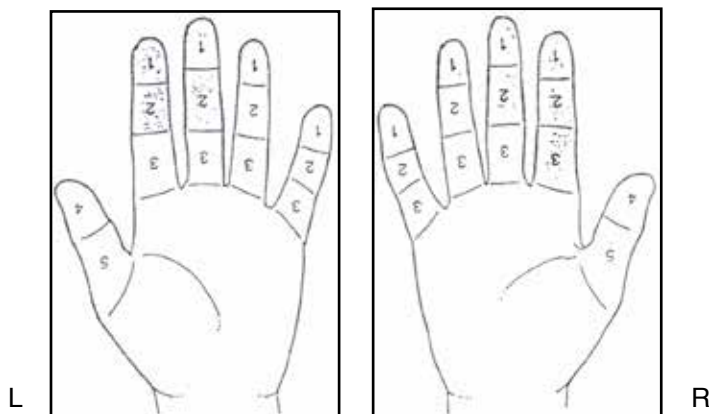
Does it occur in winter only? Yes ☐ No ☐

Winter and Summer? Yes ☐ No ☐

State most common circumstances:

When did you first notice this?

Which fingers are affected?



Are you right handed or left handed?

left handed? ☐ right handed? ☐ Leading hand: Right ☐ Left ☐

Which hand do you notice vibration most? Right ☐ Left ☐

NUMBNESS

Do your fingers go numb?

Whilst working Yes ☐ No ☐

In response to cold? Yes ☐ No ☐

With blanching? Yes ☐ No ☐

At other times? Yes ☐ No ☐

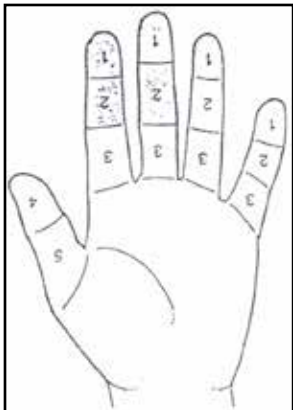
If at other times what circumstances?

HAND ARM VIBRATION ASSESSMENT QUESTIONNAIRE

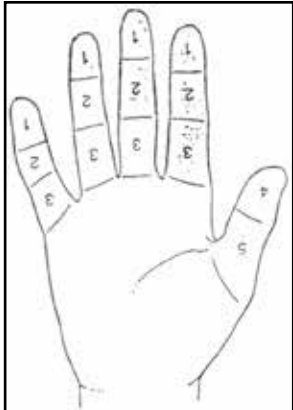
BLANCHING

Which fingers are affected?

L



R



Blanching reported ☐

Blanching witnessed ☐

LEFT HAND

Digit	Th	1	3	4	5
Total					

RIGHT HAND

Digit	Th	1	3	4	5
Total					

TINGLING (excluding transient tingling after using a vibrating tool)

Do you have tingling in the fingers?

Whilst working

Yes ☐ No ☐

In response to cold?

Yes ☐ No ☐

Do you get pain when your fingers warm up again?

Yes ☐ No ☐

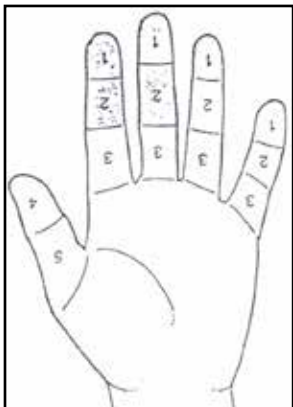
If yes, how long does it take for this pain to settle down?

At other times?

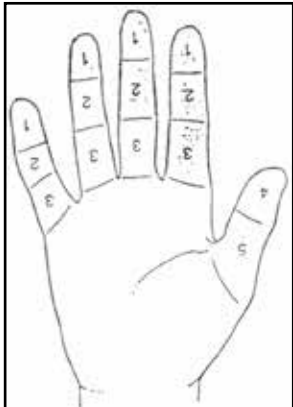
When did you first notice this?

Which fingers are affected?

L



R



HAND ARM VIBRATION ASSESSMENT QUESTIONNAIRE

MUSCULOSKELETAL

Are you experiencing any other problems with the muscles or joints of your hands/arms? Yes ☐ No ☐

Pain Yes ☐ No ☐

Swelling Yes ☐ No ☐

Stiffness Yes ☐ No ☐

Weakness Yes ☐ No ☐

If yes, give details:

Do you have any difficulty with fine movement of your fingers? Yes ☐ No ☐

If yes, is it continuous ☐ episodic ☐

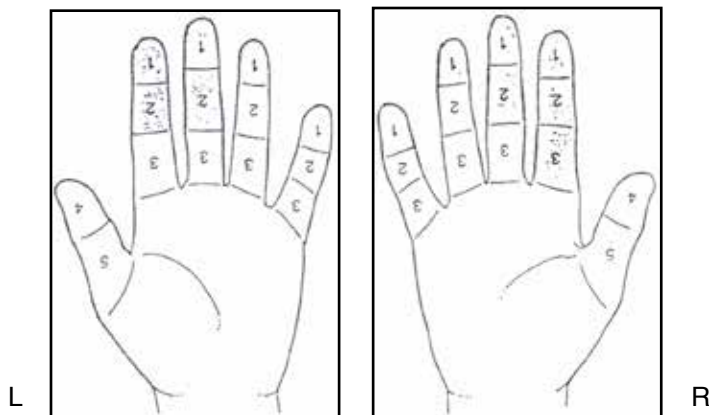
Do any of these symptoms (blanching, tingling or numbness) affect your work or leisure activities? Yes ☐ No ☐

MEDICAL EXAMINATION

Opinion of atmospheric temperature: hot/warm/cool/cold wet/dry weather

Appearance of hands

Note any signs of vascular disease, deformity, scars, calluses or muscle wasting



Describe any abnormality of neck or upper limbs

CIRCULATION, PULSE, BLOOD PRESSURE

BP	
Lying	
Sitting	

	rate		present	absent		present	absent
Radial pulse		Right			Left		
Ulnar pulse		Right			Left		



HAND ARM VIBRATION ASSESSMENT QUESTIONNAIRE

NERVOUS SYSTEM

		Normal	Abnormal		Normal	Abnormal
Light Touch	Right			Left		
Pin Prick	Right			Left		
Manual Dexterity	Right			Left		

Neurological defect can be recorded on above diagram.

HAVS RESULTS

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

Comments:

Date or Interval for Next HAVS review:
Refer to OHP - Yes/No Date referred _____ Date seen _____
Signature _____ Occupational Health Practitioner
Name (print) _____ Date _____