



## Risks of Occupational Vibration Injuries (VIBRISKS)

European Commission FP5 Project No. QLK4-2002-02650

**Title:** Hand-transmitted vibration  
Self-administered questionnaire  
Amended following 3<sup>rd</sup> consortium meeting

**Authors:** Massimo Bovenzi

**Organisation:** Trieste

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Quality of Life and Management of Living Resources Programme  
Key Action 4 - Environment and Health



## Section 1 - Personal identification

Surname \_\_\_\_\_ Name \_\_\_\_\_

Serial number |\_\_|\_\_|\_\_|\_\_|

Date |\_\_|\_\_|\_\_|

Gender: M  F

Age |\_\_|\_\_|

## Section 2 - Social history

### 2.1 *Nicotine consumption*

Do you smoke or have you ever smoked ? No  Yes

If yes, when did you start smoke regularly ? 19 \_\_

Do you still smoke ? No  Yes

If no, when did you give up to smoke ? 19 \_\_

If yes, how much did/do you smoke ? Cigarettes per day: |\_\_|

Cigars per day: |\_\_|

Pipe/rolling tobacco g per day:|\_\_|

Do you snuff or chew tobacco regularly? No  Yes

If yes, how many times per day ? |\_\_|

### 2.2 *Alcohol consumption*

Do you drink alcohol (wine, beer, etc.) ? No  Yes

How much do you drink daily? 0-1 unit  2-3 units  more than 3 units

How much do you drink weekly? 1-3 units  4-6 units  more than 6 units

Note: 1 unit = ½ pint of beer, glass of wine, or single spirit

## Section 3 – Medical history

### 3.1 Injury

Have you ever injured your hands , arms , shoulders , neck , back  ?

If yes, specify (lacerations, fractures, etc.) \_\_\_\_\_

### 3.2 Surgical treatment

Have you ever received surgery in your hands , arms , shoulders , neck , back  ?

If yes, specify \_\_\_\_\_

### 3.3 Medical treatment

Are you on any long-term medication for any chronic disease?    No        Yes   

If yes, details \_\_\_\_\_

## Section 4 - Symptoms

### 4.1 Colour changes:

Have you ever experienced any colour changes in your fingers?                      No     Yes

If no, go to section 4.2

If yes, what colours?                      blue                       white                       red

If you have experienced white finger, was the whiteness clearly demarcated?    No     Yes

If yes, when did you first notice this?    19\_\_

When did the last episode of white finger occur?

|\_\_|\_\_| day(s) ago                      |\_\_|\_\_| month(s) ago                      |\_\_|\_\_| year(s) ago

Do any members of your family suffer from white finger?    No     Yes   
(only the blood relatives)

If yes, do they work with vibrating tools?    No     Yes

If you suffer from white finger, how often does it occur ?

Several times a year                                            Several times a month                        
Several times a week                                            Several times a day

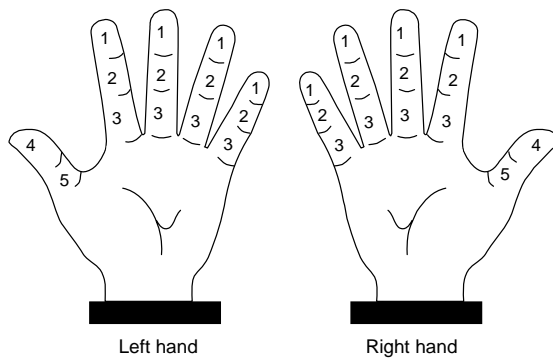
Does it occur in winter, summer or both ? Winter  Summer  Both

Does any factor trigger it?: Cold condition  Handling cold object

When feeling the vibration from vibrating tools

Others \_\_\_\_\_

Which fingers/thumbs are affected with whiteness?  
(indicate by shading the parts that go white on the diagram)



Does the condition interfere with any leisure activities? No  Yes

Does the condition interfere with any work activities? No  Yes

#### 4.2 *Tingling:*

Have you ever experienced tingling in the fingers ? No  Yes

If yes, when did you first notice this ? 19\_\_

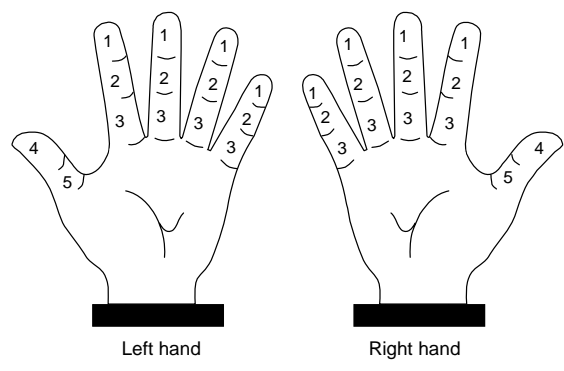
If yes, when ?

While working with vibrating tools  After working with vibrating tools

After exposure to cold  During white finger  After white finger

At night  At other time \_\_\_\_\_

Which fingers/thumbs are affected with tingling?  
 (indicate by shading the parts that get tingling on the diagram)



Does the condition interfere with any leisure activities? No  Yes

Does the condition interfere with any work activities? No  Yes

4.3 Numbness:

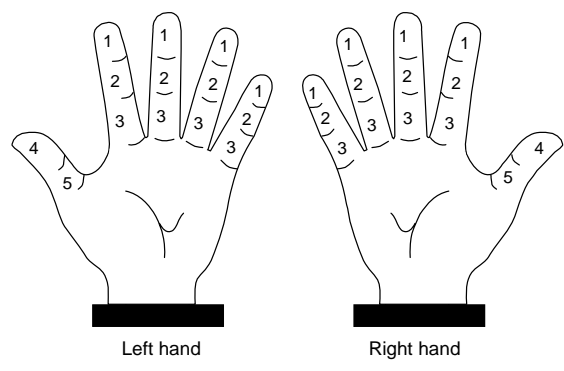
Do your fingers go numb ? No  Yes

If yes, when did you first notice this? 19\_\_

If yes, when ?

- While working with vibrating tools  After working with vibrating tools
- After exposure to cold  During white finger  After white finger
- At night  At other time \_\_\_\_\_

Which fingers/thumbs are affected with numbness?  
 (indicate by shading the parts that get numbness on the diagram)



Does the condition interfere with any leisure activities? No  Yes

Does the condition interfere with any work activities? No  Yes

4.4 *Musculoskeletal complaints in the upper limbs and neck:*

Did/do you suffer from muscle/joint troubles in the upper limbs? No  Yes

If yes, when: in the LAST 7 DAYS? , in the LAST 12 MONTHS? , or in the PAST?

Did/do you suffer from muscle/joint troubles in the neck? No  Yes

If yes, when: in the LAST 7 DAYS? , in the LAST 12 MONTHS? , or in the PAST?

4.5 *Effects of symptoms in the hands and fingers*

In the PAST 12 MONTHS have symptoms in the hands caused any difficulty with the following activities?:

	No difficulty	Difficult but not impossible	Impossible
	_____	_____	_____
Turn a door knob or lever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open a tight jar lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Put on a jacket or pullover	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fasten buttons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handling and picking up coins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pour from a jug or a pot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Did symptoms in the hands affect your work ability? No  Yes

If yes, when: in the LAST 7 DAYS? , in the LAST 12 MONTHS?

Was there any reduction in your work output in the LAST 7 DAYS due to the above symptoms? No  Yes