WAYNE STATE UNIVERSITY

Office of Environmental Health and Safety
5425 Woodward Ave., Suite 300
Detroit Michigan 48202
(313) 577-1200, FAX (313) 993-4079
http://www.oehs.wayne.edu

Ergonomics Program: Symptoms Survey

All information disclosed here will remain confidential.

Name: ________________________ Date: ______________________

Dept: _________________________ Job/Position: ______________________

Other Jobs you have done in the last year (for more than 2 weeks)

Dept: __________ Position held: ____________ Time on this Job: _____________

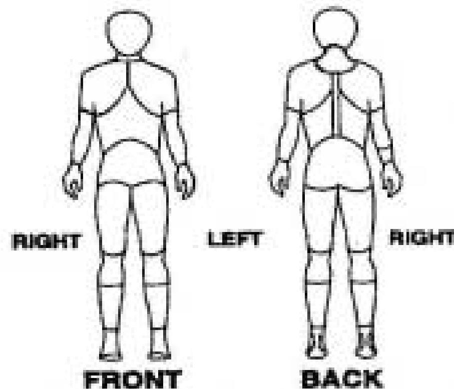
Dept: __________ Position held: ____________ Time on this Job: _____________

(Include Jobs you worked on the most)

Have you had any pain or discomfort in the upper extremities during the last year?

- ❑ Yes
- ❑ No

If YES, carefully shade in area(s) of the drawing where you have the MOST problems:



Adapted from NIOSH's Elements of Ergonomics Programs
Version 5/22/2001

Check the area(s) below where you have pain/discomfort. If you have more than one area of problems, make additional copies of this page and complete a separate page for each area.

❑ Neck ❑ Shoulder ❑ Elbow / Forearm ❑ Hand/Wrist ❑ Fingers
❑ Upper Back ❑ Low Back ❑ Thigh / Knee ❑ Lower Leg ❑ Ankle/foot

1. Put a check by the words that best describe the problem.

❑ Aching ❑ Numbness ❑ Tingling ❑ Burning ❑ Pain ❑ Weakness
❑ Cramping ❑ Swelling ❑ Stiffness ❑ Other__________________

2. When did you first notice the problem? Month_____________ Year______________

3. How long does each episode last? (Mark an X along the line)

__________/ __________/ __________/ ____________
1 hour 1 day 1 week 6 months

4. How many separate episodes have you had in the past year?_______________________

5. What task do you think caused the problem? _____________________________________

____

6. Have you had this problem within the past week or two? ______________

7. How would you rate the pain/discomfort, etc. of this problem? (Mark an **X** on the line)

NOW

____
None *Unbearable*

When it is the WORST

____
None *Unbearable*

8. Have you had any medical treatment for this problem? ______YES ______NO

9. If NO, why not?____

10. If Yes, where did you receive treatment?

❑ University Health Center Number of times in past year ____________
❑ Personal Doctor Number of times in past year ____________
❑ Other Number of times in past year ____________

Did treatment help? ______Yes ______No

11. How many workdays have you lost in the last year because of this problem? ________

12. How many days in the last year were you on restricted or light duty?_______________

13. What do you think would help to improve this problem and your symptoms?_________