ERGONOMIC QUESTIONNAIRE

Name: __________________________ Date: ______ Phone: ______________

Job Title: ________________________ Job Address: _______________________

Gender: _____ M _____ F Height: ______ Weight: ______

Supervisor: ______________________ Supervisor’s Title: __________________

Department: ______________________

Years at current position: __________ Hours worked per week: __________

Fee information is available at: http://www.ehs.iastate.edu/fee-schedule

Account number __________________________

Work Environment and Symptoms

Daily work duties:

________________________________________________________________________

Work-related activities that aggravate your condition:

________________________________________________________________________

If you work at a computer, on average how many hours per day do you do so? ______

Do you experience eyestrain? _____ Y _____ N If yes, please describe symptoms and frequency:

________________________________________________________________________

Please note your dominant hand: _____ Right _____ Left

Do you currently experience discomfort while working? _____ Yes _____ No

If yes, what are the symptoms? Please specify right or left where appropriate and be specific.

________________________________________________________________________

Approximate date symptoms first noticed: ____________________________
Medical Information

Have you seen a physician for this problem?  ______ Yes  ______ No

_____ Personal Physician  _____ Worker’s compensation Physician  _____ Not Applicable

What was the diagnosis?  ____________________________________________________________

________________________________________________________________________________

What tests, if any, were conducted to confirm the diagnosis?  __________________________________________________________

________________________________________________________________________________

Which treatments, if any, has your doctor prescribed?

_____ Anti-inflammatory drugs  _____ Surgery

_____ Ice/heat  _____ Splint(s)  Currently used?  _____ Y  _____ N

_____ Physical Therapy  _____ Chiropractic care

_____ Steroid Injection  _____ Rest  (Describe)  ________________________________

The medical conditions listed below may predispose individuals to repetitive strain injury. If you have any of the listed conditions and are comfortable disclosing them, please do so.

_____ Rheumatoid Arthritis  _____ Overweight  _____ Birth control/hormonal drugs

_____ Diabetes mellitus  _____ Hypothyroidism  _____ Smoking

_____ Pregnancy  _____ Myalgia  _____ Lupus

Personal Information

List any hobbies or activities done on a regular basis outside of work, e.g., sewing, bowling, bicycling, knitting, motorcycling, computer games, etc...

________________________________________________________________________________

________________________________________________________________________________

To the best of my knowledge, the above information is accurate and complete.

Signed:  ___________________________________________  Date:  _________________________