MEDICAL UNIVERSITY of SOUTH CAROLINA

ERGONOMICS PROGRAM SYMPTOMS SURVEY

University Risk Management
Occupational Safety and Health
19 Hagood Avenue, MSC 184
Charleston, SC 29425
Office 843.792.3604

Date ____________________

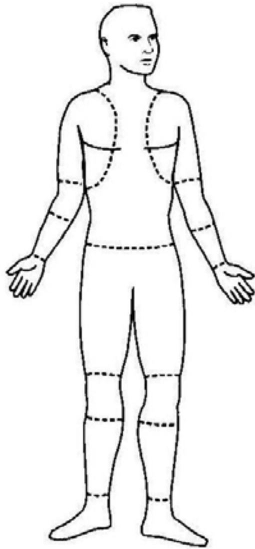
Name (Last, First, Middle Initial) ______________________ Date of Birth: ______________ Date of Hire: ______________

Campus Address (Ex: North Tower Rm: 295): ______________________ Work Number: ______________ Hours worked/week: ______________

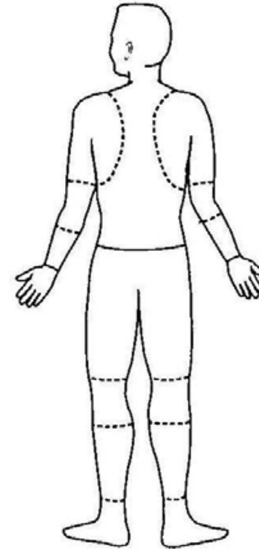
Have you had any pain or discomfort during the last year?

☐ Yes ☐ No

If YES carefully shade in the areas of the drawing where the pain occurs.



Front



Back

Check Area:

☐ Neck ☐ Shoulder ☐ Elbow/Forearm ☐ Hand/Wrist ☐ Fingers

☐ Upper Back ☐ Low Back ☐ Thigh/Knee ☐ Low Leg ☐ Ankle/Foot

Please put a check by the word(s) that best describe your problem.

☐ Aching ☐ Numbness (asleep) ☐ Tingling

☐ Burning ☐ Pain ☐ Weakness

☐ Cramping ☐ Swelling ☐ Other

☐ Loss of Color ☐ Stiffness

When did you first notice the problem? ______________ (Month) ______________ (Year)

(Continued)

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How long does each episode last?

Signed By

☐ 1 Hour ☐ 1 Day ☐ 1 Week ☐ 1 Month ☐ 6 Months

How many separate episodes have you had in the last year? ______________________________

What do you think caused this problem? ______________________________

____

Have you had this problem in the last 7 days? ☐ Yes ☐ No

On a scale of 0 to 10 (with 0 = no pain and 10 = E.R), how would you rate this problem?

NOW: ______________ When it is the WORST: ______________

What makes it better? ______________________________

____

Have you had medical treatment for this problem? ☐ Yes ☐ No

If, NO, why not? ______________________________

If YES, where did you receive treatment?

☐ Employee Health Services Times in past year ______________

☐ Personal doctor Times in past year ______________

☐ Other (please specify) Times in past year ______________

____

Did treatment help? ☐ Yes ☐ No

How much time have you lost in the last year because of this problem? ________ Days

How many days in the last year were you on restricted or light duty because of this problem? ________Days

Please comment on what you think would improve your symptoms.

____

____

____

____

Supervisor: ______________ Phone Number: ______________

Please have your supervisor sign and fax completed forms to Occupational Safety and Health Programs (792-0284).