FLORIDA INTERNATIONAL UNIVERSITY
Environmental Health & Safety
11200 SW 8TH Street, CSC 162 ● Miami, FL 33199 ● Tel (305) 348-2621 ● Fax (305) 348-3574 ● http://ehs.fiu.edu

ERGONOMICS SURVEY

☐ Routine Investigation
☐ Special Request
☐ Workers' Compensation Related

Name: _____ Department: _____
Supervisor: _____ Location: _____
Hours Worked/week: _____ Time on THIS job, years ___ months ___

1. List routine task operations:

_____ _____
_____ _____
_____ _____
_____ _____

2. Briefly describe primary work process:

_____
_____
_____
_____

Please identify other jobs you have done in the last year (for more than 2 weeks)

Dept. **FIU** Job Name: _____ Time on this job, months ___ weeks ___

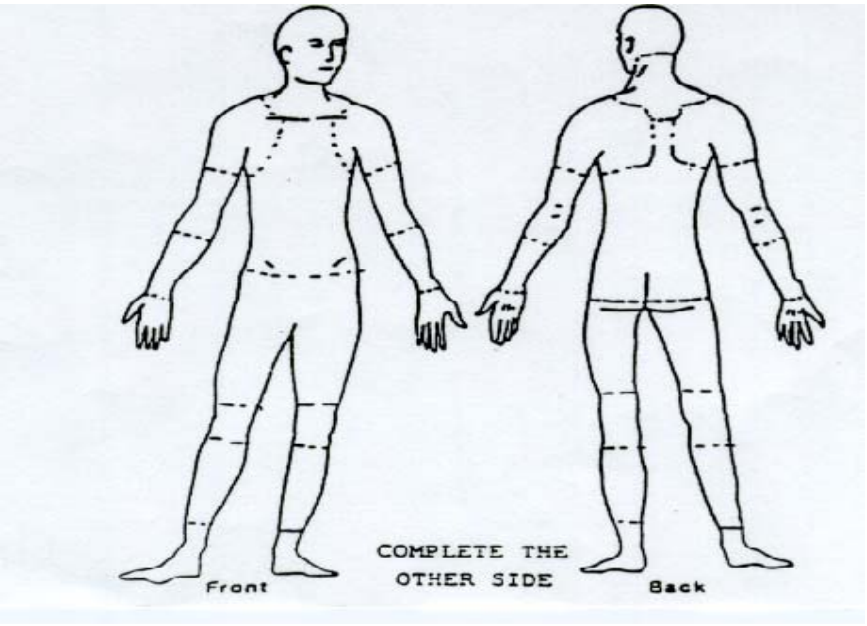
Dept. **Other** Job Name: _____ Time on this job, months ___ weeks ___

(if more than 2 jobs, include those you worked on the most)

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

☐ Yes ☐ No (If **No**, stop here)

3a. If Yes, carefully shade in the area of the drawing which bothers you most.



4. What other areas bother you? (Check all that are applicable)

☐ Neck	☐ Shoulder	☐ Elbow/Forearms	☐ Hand/Wrist
☐ Upper Back	☐ Thigh/Knee	☐ Lower Leg	☐ Ankle/Foot

5. Please check the word (s) that best describe your problem

☐ Aching	☐ Burning	☐ Cramping
☐ Loss of Color	☐ Numbness (asleep)	☐ Pain
☐ Swelling	☐ Stiffness	☐ Tingling
o Weakness	o Other	

6. When did you notice the problem ? _____ Month _____ Year

7. How long does each episode last ? _____

8. How many separate episodes have you had in the last year? _____

9. What do you think caused the problem?

_____

_____

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

How would you rate this problem (mark with an X on the line)

Now _____
None Unbearable

When it was WORST

_____
None Unbearable

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

    11a. If No, why not _____

    11b. If Yes, where did you receive treatment?

    ☐ Health & Wellness Center Times in past year _____
    ☐ Personal doctor Times in past year _____
    ☐ Other _____ Times in past year _____

    11c. If Yes, did the treatment help? ☐ Yes ☐ No

12. How much time have you lost in the last year because of this problem? _____ days

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

14. Please comment on what you think would improve your symptoms (e.g. workstation, equipment & tools, procedures, methods, more rest periods, etc.)