



COMPUTER WORKSTATION ERGONOMIC QUESTIONNAIRE

Purpose: The information in this form, in combination with the information obtained during the evaluation, will be used to compile the final ergonomic report.

Directions: Complete each part of this questionnaire. Save the completed form and submit it via e-mail as an attachment to [Marta Figueroa](mailto:marta.figueroa@umdnj.edu) (Newark), [Lindsey Kayman](mailto:lindsey.kayman@umdnj.edu) (Plisc/NB), or [Tom Boyle](mailto:tom.boyle@umdnj.edu) (Stratford/Camden), or print out and return to your campus EOHSS office via fax or interoffice mail: <http://www2.umdnj.edu/eohssweb/publications/directory.htm#Office>

Date	
Name	
Title	
School/Unit	
Building/Room	
Department	
Campus	
Phone	
Email	
Supervisor	
Title	

Please be sure to notify your supervisor regarding your request for an ergonomic evaluation.

1. What is your reason for contacting EOHSS? _____
2. How long have you worked at this workstation? _____
3. Do you have any specific concerns about your current workstation? General concerns?

4. How much time do you spend on the computer during an average workday?
 0 to 2 hours 2 to 4 hours 4 to 6 hours 6 to 8 hours
5. What do you do while working on the computer? Please check all that apply.
 e-mails searching the Internet spreadsheets writing original documents other
6. How much time do you spend at your desk doing paperwork, reading paper documents and other non-computer activities during an average workday?
 0 to 2 hours 2 to 4 hours 4 to 6 hours 6 to 8 hours
7. How many times do you answer the phone during an average workday? _____
8. How much time do you spend on the phone during an average workday?
 0 to 2 hours 2 to 4 hours 4 to 6 hours 6 to 8 hours
9. How often are you on the phone while conducting other tasks?
 0 to 2 hours 2 to 4 hours 4 to 6 hours 6 to 8 hours

10. How often do you leave your workstation to perform other work related activities or for breaks? _____ For approximately how long? _____

11. Physical characteristics:

• Height : _____

• Weight Please select one:

Under 100 lbs

100 to 300 lbs

Over 300 lbs

12. Do you have any current health concerns that you believe to be related to your work at the computer and/or your workstation? Yes No

13. If yes, check the area(s) of discomfort and circle the number which best describes the level (1= slight discomfort, 3=moderate, 5=significant pain)

Check all that apply	Area of Body	Right	Left
<input type="checkbox"/>	Fingers, thumbs	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
<input type="checkbox"/>	Hand, wrist	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
<input type="checkbox"/>	Forearm, elbow	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
<input type="checkbox"/>	Upper arm, shoulder	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
<input type="checkbox"/>	Thigh, knee	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
<input type="checkbox"/>	Lower leg	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
<input type="checkbox"/>	Foot, ankle	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
<input type="checkbox"/>	Neck	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 4 <input type="checkbox"/> 5
<input type="checkbox"/>	Upper middle back	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 4 <input type="checkbox"/> 5
<input type="checkbox"/>	Lower back	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 4 <input type="checkbox"/> 5
<input type="checkbox"/>	Other: _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 4 <input type="checkbox"/> 5

14. If have health problems related to your work on the computer, have you filed an Incident Report form (available from General Stores) with Risk and Claims? Yes No

a) If no, reason why: _____

b) If yes, were you referred to a Doctor? Yes No

15. Have you seen your own Physician? Yes No

16. Please provide any additional information that may assist in your ergonomic evaluation:
