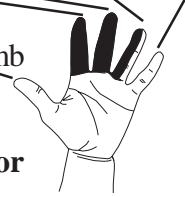


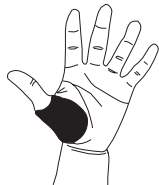
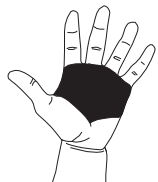
The shaded areas in the diagrams below show the position of the body parts referred to in the questionnaire. Please answer by marking the appropriate box.

Index Middle Ring Pinkie

Thumb



Complete only for  
LEFT HAND



During the last work week  
how often did you experience  
ache, pain, discomfort in:

If you experienced ache, pain,  
discomfort, how uncomfortable  
was this?

If you experienced ache,  
pain, discomfort, did  
this interfere with your  
ability to work?

Area A (Shaded area)	Never <input type="checkbox"/> 1-2 times last week <input type="checkbox"/> 3-4 times last week <input type="checkbox"/> Once every day <input type="checkbox"/> Several times every day <input type="checkbox"/>	Slightly uncomfortable <input type="checkbox"/> Moderately uncomfortable <input type="checkbox"/> Very uncomfortable <input type="checkbox"/>	Not at all <input type="checkbox"/> Slightly interfered <input type="checkbox"/> Substantially interfered <input type="checkbox"/>
Area B (Shaded area)	Never <input type="checkbox"/> 1-2 times last week <input type="checkbox"/> 3-4 times last week <input type="checkbox"/> Once every day <input type="checkbox"/> Several times every day <input type="checkbox"/>	Slightly uncomfortable <input type="checkbox"/> Moderately uncomfortable <input type="checkbox"/> Very uncomfortable <input type="checkbox"/>	Not at all <input type="checkbox"/> Slightly interfered <input type="checkbox"/> Substantially interfered <input type="checkbox"/>
Area C (Shaded area)	Never <input type="checkbox"/> 1-2 times last week <input type="checkbox"/> 3-4 times last week <input type="checkbox"/> Once every day <input type="checkbox"/> Several times every day <input type="checkbox"/>	Slightly uncomfortable <input type="checkbox"/> Moderately uncomfortable <input type="checkbox"/> Very uncomfortable <input type="checkbox"/>	Not at all <input type="checkbox"/> Slightly interfered <input type="checkbox"/> Substantially interfered <input type="checkbox"/>
Area D (Shaded area)	Never <input type="checkbox"/> 1-2 times last week <input type="checkbox"/> 3-4 times last week <input type="checkbox"/> Once every day <input type="checkbox"/> Several times every day <input type="checkbox"/>	Slightly uncomfortable <input type="checkbox"/> Moderately uncomfortable <input type="checkbox"/> Very uncomfortable <input type="checkbox"/>	Not at all <input type="checkbox"/> Slightly interfered <input type="checkbox"/> Substantially interfered <input type="checkbox"/>
Area E (Shaded area)	Never <input type="checkbox"/> 1-2 times last week <input type="checkbox"/> 3-4 times last week <input type="checkbox"/> Once every day <input type="checkbox"/> Several times every day <input type="checkbox"/>	Slightly uncomfortable <input type="checkbox"/> Moderately uncomfortable <input type="checkbox"/> Very uncomfortable <input type="checkbox"/>	Not at all <input type="checkbox"/> Slightly interfered <input type="checkbox"/> Substantially interfered <input type="checkbox"/>
Area F (Shaded area)	Never <input type="checkbox"/> 1-2 times last week <input type="checkbox"/> 3-4 times last week <input type="checkbox"/> Once every day <input type="checkbox"/> Several times every day <input type="checkbox"/>	Slightly uncomfortable <input type="checkbox"/> Moderately uncomfortable <input type="checkbox"/> Very uncomfortable <input type="checkbox"/>	Not at all <input type="checkbox"/> Slightly interfered <input type="checkbox"/> Substantially interfered <input type="checkbox"/>