Ergonomic Evaluation for Office Workers

Name: _____ Date: _____

Department: _____ Campus Box #: _____

Telephone Number: _____ Fax Number: _____

Building: _____ Room Number: _____

Email Address: _____

Supervisor: _____

Evaluation Date/Time: _____

Symptoms: Respond to each question by marking the appropriate box to indicate how often you have recently experienced the described symptom.

	2x month or less	1x per week or less	2-4 days/week	Daily
Pain or stiffness in your arms				
Pain or stiffness in you neck				
Pain or stiffness in your shoulders				
Pain or stiffness in your back				
Pain or stiffness in your wrist or hand				
Pain or stiffness in your legs				
Eyestrain				

Other Factors: Indicate whether the following create discomfort for you by marking the appropriate box.

	2x month or less	1x per week or less	2-4 days/week	Daily
Chair				
Backrest				
Legroom				
Table height				
Keyboard height				
Monitor Height				
Mouse				
Size of work space				
Lighting level				
Glare from light				
Reflections on screen				
Place to rest arms				
Wear Glasses	☐ Yes	☐ No		
Wear Contacts	☐ Yes	☐ No		
Daily computer use	☐ 2 hours	☐ 4 hours	☐ 6+ hours	
Daily Phone Use	☐ <1 hour	☐ 1-4 hours	☐ 4+ hours	

Do you have any other comments you think might be relevant?

Please Return Completed Form To: University of Florida Environmental Health & Safety • Risk Management Office

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