Medical History and Examination for Coal Mine Workers' Pneumoconiosis

Reset Print

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

Note: This report is authorized by law (30 USC 901 et. seq) and required to receive a benefit. The results of this interpretation will aid in determining the miner's eligibility for black lung benefits. Disclosure of a social security number is voluntary. The failure to disclose such number will not result in the denial of any right, benefit, or privilege to which the claimant may be entitled. The method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974, and OMB Cir. No. 108.

A. Patient Information

(Please type all responses.)

OMB No.: 1215-0090
Expires: 08-31-2011

1. Name and Address

name:

city: state: zip:

2. DOL Claim No.

3. Telephone No.

4. Date of Exam

5. Date of Birth

6. Personal Physician (name, address, phone no.)

name:

city: state: zip:

7. Examining Physician (name, address, phone no.)

state: zip:

B. Employment History

(Please type or neatly print all responses.)

☐ "Employment History", Form CM-911a, or equivalent (dated) is attached. Please review the form and, with the miner's help, **complete only blocks 1.a, below,** describing his/her most recent coal mine job (of at least one year's duration). Then, move on to "C. Patient History"

☐ CM-911a is **not** attached - complete both sections, 1. and 2., below.

1. Coal Mine Employment - CME. List most recent employment first. In line (a.) describe the last job of at least one year's duration. (Include in all lines any coal mine construction or transportation work, or work in a mine preparation facility.)

Name of Company	Job Title and Description of Job's Physical Requirements	From	To
a. Last CME held at least one year.			
b. Other CME:			

c. Additional number of years in CME not described above: _ _ years.

2. **Other Employment - Not CME.** (If the employment exposed the patient to an occupational toxic inhalant hazard, describe the inhalant under "Job Title and Description".)

Name of Company	Job Title and Description	From (mm/yy)	To (mm/yy)

C. Patient History (Family - Medical - Social)

(Please type or neatly print all responses.)

1. Family History.

Have the patient's parents, children, or other "blood" relatives ever had any of the following:

	Yes	No		Yes	No
High blood pressure	☐	☐	Asthma	☐	☐
Heart Disease	☐	☐	Allergies	☐	☐
Tuberculosis	☐	☐	Emphysema	☐	☐
Diabetes	☐	☐	Stroke	☐	☐
Cancer	☐	☐			

If "Yes," identify family member

C. Patient History (continued) (Please type all responses.)

2. Individual Health/Medical History.

a. Does the patient have a history of:

Yes	No		When Manifested	Yes	No		When Manifested
☐	☐	Frequent Colds		☐	☐	Arthritis	
☐	☐	Pneumonia		☐	☐	Heart Disease/Problems	
☐	☐	Pleurisy		☐	☐	Allergies	
☐	☐	Attacks of wheezing		☐	☐	Cancer (of)	
☐	☐	Tuberculosis		☐	☐	Diabetes Mellitus	
☐	☐	Chronic bronchitis		☐	☐	High Blood Pressure	
☐	☐	Bronchial Asthma		☐	☐	Connective Tissue Disease	

b. Other Significant Conditions or Serious Illnesses (when diagnosed?)

c. Hospitalizations (reasons and dates):

d. Surgery:

3. Social History.

a. Smoking History

☐ Never Smoked

☐ Has Stopped Smoking
Started: ; Stopped:
Smoked what?
How much: 1 cigarette(s) per day

☐ Currently Smoking
Started:
Smokes what?
How much: 1 cigarette(s) per month

b. Other Pertinent Social History (e.g. drug or alcohol use; strenuous hobbies):

D. Present Illness/Physical Examination (Please type or neatly print all responses.)

1. Chief Complaints/Symptoms - as described by patient. Please comment on all "Yes" answers (e.g. describe frequency, duration, and/or severity of symptoms).

Yes	No		Comments
☐	☐	Sputum (daily?)	
☐	☐	Wheezing (daily?)	
☐	☐	Dyspnea (quantitate)	
☐	☐	Cough	
☐	☐	Hemoptysis	
☐	☐	Chest pain (Inciting Factor):	
☐	☐	Orthopnea	
☐	☐	Ankle edema	
☐	☐	Paroxysmal Nocturnal Dyspnea	

(Indicate in D.4., next page, any of the above symptoms manifested during the exam.)

2. Other complaints. (Include here the patient's description of any limitations in physical activities like walking, climbing, and lifting.)

D. Present Illness/Physical Exam (continued) (Please type all responses.)

3. Current Treatment (including medications):

4. **Physical Findings:** Based on Your Physical Examination.
(Show all findings, especially those pertinent to the respiratory system and the cardiovascular system.)

a. Fill in the appropriate data or response:

General		**Thorax & Lungs**		**Nose**		**Abdomen**	
		Inspection		Membranes		Peristalsis	
Height				Obstruction		Tenderness	
Weight		Palpation		Discharge		Ascites	
				Septum		Liver	
Temperature		Percussion		Sinuses		Spleen	
Pulse						Kidneys	
Respiration		Auscultation		**Throat**		Urinary bladder	
B.P. rt. arm				Erythema		Masses	
B.P. lf. arm				Exudate		Hernia	
Development		**Heart**		Tonsils			
Nutrition		Peripheral Pulse		Pharynx			
Hydration		PMI					
Orientation		Pulsation		**Neck**			
Mentation		Epigastric Cardiac Pulsation		Masses			
Personality				Thyroid			
Mood		Thrills		Trachea			
		Rhythm		Arteries			
Extremities		Sounds		Veins			
Color		Gallop					
Clubbing		Murmurs		**Musculoskeletal**			
Edema				Spine			
Varicosities		Friction rub		Joints			
Arterial Pulses				Muscles			

b. Other relevant findings - narrative summary:

5. Summary of Diagnostic Testing -in the space below, check the applicable block(s) next to any test results (including those conducted in conjunction with this physical exam) which you reviewed and relied upon, at least in part, to base your medical assessments and conclusions - especially those on the next page. Be sure to show the date(s) of each test, and summarize the results.

		Dates	**Summary of Results**
☐	Chest X-ray		
☐	Vent Study (PFS)		
☐	Arterial Blood Gas		
☐	Other:		
☐	Other:		

D. Present Illness/Physical Exam (Continued) (Please type all responses.)

6. **Cardiopulmonary Diagnosis (es): (And** provide the **basis (as)** for your stated diagnosis (es).)

7. **Etiology of Cardiopulmonary Diagnosis (es):(**List Primary and Secondary Causes - if applicable - and Provide Rationale.)

8. **Impairment** - If the patient has chronic respiratory or pulmonary disease, give your medical assessment - With Rationale - of:

a. The degree of severity of the impairment, particularly in terms of the extent to which the impairment prevents the patient from performing his/her current or last coal mine job of one year's duration: (Refer to section B.1.a. of this form.)

b. The extent to which each of the diagnoses listed in D.6. above contributes to the impairment:

9. **Non-Cardiopulmonary Diagnosis** -if the patient has any disabling **non-respiratory condition(s)** indicate what the condition is and describe its degree of impairment, especially as it may affect the patient's ability to perform his coal mine work:

E. Physician Referral

Should this patient be referred to another physician for further evaluation? ☐ Y ☐ N Has referral been made? ☐ Y ☐ N
For what reason?

F. Physician Signature

I certify that the information furnished is correct and am aware that my signature attests to its accuracy. I am also aware that any person who willfully makes any false or misleading statement or representation in support of an application for benefits shall be guilty under Title 30 USC 941 of a misdemeanor and subject to a fine of up to $1,000., or to imprisonment for up to one year, or both.

Signature: Date:

(Physician's name should be typewritten on front page of this form.)

Public Burden Statement

We estimate that it will take an average of 30 minutes per response to complete this information collection, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Division of Coal Mine Workers' Compensation, U.S. Department of Labor, Room N-3464, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.