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Patient Name: _____ Date of Birth: _____ Date: _____

Physical Exam Form

Section 1. Patient Information *(to be filled out by patient)*

Section 1. Información de paciente *(ser completado por el paciente)*

ALLERGIES TO MEDICATIONS
ALERGIAS A MEDICAMENTOS

List all ***known or suspected*** allergies to medication, food or environment:
Indique todas las alergias conocidas o sospechadas a medicamentos, alimentos o medioambiente:

☐ No Known Drug Allergies *(Ninguna alergia conocida a medicamentos)*

☐ Allergies or Sensitivities. Please list *(Alergias o sensibilidades. Por favor indique)*

_____

_____

_____

CURRENT MEDICATIONS
MEDICAMENTOS ACTUALES

List any medications that you are currently taking, include vitamins and supplements:
Haga una lista de los medicamentos que está tomando actualmente, incluya vitaminas y suplementos:

☐ None *(Nada)*

Name *(Nombre)*	Dose & Directions *(Dosis e indicaciones)*	Reason *(Razón)*

_____

_____

_____

_____

SURGICAL AND HOSPITALIZATION HISTORY
HISTORIAL QUIRÚRGICO Y DE HOSPITALIZACIÓN

List any surgeries or hospitalizations you have had, include the year and reason:
Haga una lista de las cirugías u hospitalizaciones que haya tenido, incluya el año y la razón

☐ None *(Nada)*

_____

_____

_____

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PERSONAL HEALTH HISTORY
HISTORIAL DE PERSONAL DE SALUD

Do you have or have you ever had:
***Tienes o has tenido alguna vez*:**

1. Head/brain injuries or illness (e.g. concussion)/ *Cabeza/ o enfermedades/lesiones cerebrales* ..... ☐ No ☐ Yes
2. Seizures, epilepsy/ *Consulsiones o epilepsia* ..... ☐ No ☐ Yes
3. Eye Problems (except glasses or contacts/ *Problemas oculares (except anteojos o lentes de contacto)* ..... ☐ No ☐ Yes
4. Ear and, or hearing problems/ Problemas de oido y o problemas de audicion ..... ☐ No ☐ Yes
5. Heart disease, heart attack, bypass, or other heart problems ..... ☐ No ☐ Yes
   Enfermedad cardiac, ataque cardiaco, derivacion u otros problemas cardiacos
6. Pacemaker, stent, implantable devices, or other heart procedures ..... ☐ No ☐ Yes
   Marcapasos, stent, dispositivos implantables u otros procedimientos cardiacos
7. High blood pressure/ *Alta presion sanguinea* ..... ☐ No ☐ Yes
8. High cholesterol/ *Colesterol alto* ..... ☐ No ☐ Yes
9. Chronic (long-term) cough, shortness of breath, or other breathing problems ..... ☐ No ☐ Yes
   Tos cronica, dificultad para respirar u otros problmas respiratorios
10. Lung disease (e.g. asthma)/ *Enfermedad pulmonar (asma)* ..... ☐ No ☐ Yes
11. Kidney problems, kidney stones, or pain/problems with urination ..... ☐ No ☐ Yes
    Problemas renales, calculos renales o dolor al orinar
12. Stomach, liver, or digestive problems/ *Problemas estomacales, hepaticos o digestivos* ..... ☐ No ☐ Yes
13. Diabetes or blood sugar problems/ *Diabetes o problemas de azucar en la sangre* ..... ☐ No ☐ Yes
14. Do you use insulin/ *Usas insulina* ..... ☐ No ☐ Yes
15. Anxiety, depression, nervousness, other mental health problems ..... ☐ No ☐ Yes
    Ansiedad, depression, nerviosismo u otros problemas de salud mental
16. Fainting or passing out/ *Desmayos* ..... ☐ No ☐ Yes
17. Dizziness, headaches, numbness, tingling, or memory loss ..... ☐ No ☐ Yes
    Mareos, dolores de Cabeza, entumecimiento, hormigueo o Perdida de memoria
18. Unexplained weight loss or gain without any changes to diet or lifestyle ..... ☐ No ☐ Yes
    Perdida de peso sin explicación o subir de peso sin ningun cambio en la dieta o el estilo de vida
19. Stroke, mini-stroke (TIA), paralysis, or weakness ..... ☐ No ☐ Yes
    Derrame cerebral/ cerebrovascular (mini), paralisis o debilidad
20. Missing or limited use of arm, hand, finger, leg, foot, toe ..... ☐ No ☐ Yes
    Falta de ó limitado de brazo, mano, dedo, pierna, pie o dedo del pie
21. Neck or back problems/ *Problemas en el cuello o la espalda* ..... ☐ No ☐ Yes
22. Bone, muscle, joint, or nerve problems/ *Problemas de huesos, musculos, articulaciones o nervios* ..... ☐ No ☐ Yes
23. Blood clots or bleeding problems/ *Coagulos de sangre o problemas de sangrado* ..... ☐ No ☐ Yes
24. Cancer/ *Cancer* ..... ☐ No ☐ Yes
25. Chronic (long-term) infection or other chronic diseases/ *Infección cronica u otra enfermedad cronicaI* ..... ☐ No ☐ Yes
26. Sleep disorder, pauses in breathing while asleep, daytime sleepiness, loud snoring ..... ☐ No ☐ Yes
    Trastorno del sueno, pausas en la respiración mientras esta dormido, somnolencia durante el dia o ronquidos fuertes
27. Have you ever spent a night in the hospital/ *Alguna vez pasó una noche en el hospital* ..... ☐ No ☐ Yes
28. Have you ever had a broken bone/ *Alguna quebradura a un hueso* ..... ☐ No ☐ Yes
29. Have you ever used or do you currently use tobacco/ *Alguna vez ha usado o usa actualmente tabaco* ..... ☐ No ☐ Yes
30. Do you drink alcohol/ *Bebe alcohol* ..... ☐ No ☐ Yes

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OTHER HEALTH CONDITION(S) NOT LISTED OR DESCRIBED ABOVE ***ALGUN OTRA CONDICIÓN MÉDICA QUE NO SE MENCIONO***

PLEASE COMMENT ON ANY "YES" RESPONSES TO QUESTIONS 1-30 ABOVE ***FAVOR DE INCLUIR UN COMENTARIO EN CUALQUIR "SÍ" DE LAS PREGUNTAS***

WORK HISTORY
HISTORIAL DE TRABAJO

1. Are you currently working/*¿Esta trabajando*? ☐ No ☐ Yes. If yes/ *En caso afirmativo,*

☐ Full-time/ *Tiempo completo* ☐ Part-time/ *Medio tiempo* ☐ As Needed/ *Segun sea necesario*

2. Occupation/ *Ocupación*: _____ Years/ *Años*: _____

3. Name of Employer/ *Nombre de empleador*: _____ How Long/ *Cuanto tiempo*: _____

4. Are you employed anywhere else/ *Estas empleado en otro lado*? ☐ No ☐ Yes. Where/ *Donde*: _____

5. Are you required to wear a respirator at work/ *Se le requirere usar un respirador en el trabajo*? ☐ No ☐ Yes

If yes, how many hours per week/ *En caso afirmativo, cuantas horas por semana*: _____

6. Have you ever been exposed to/ *Alguna vez has estado expuesto a*:

☐ Silica/ *Silice* ☐ Asbestos/ *Asmianto* ☐ Chromium/ *Cromo* ☐ Lead/ *Plomo de metal*

7. Do you operate machinery or power tools/ *Maneja maquinaria o herramientas electricas*? ☐ No ☐ Yes

8. Have you ever suffered a work-related injury/ *alguna vez sufrio una lesion relacionada con el trabajo*? ☐ No ☐ Yes

If yes, please explain/ *En caso afirmativo, expliquielo porfavor:* _____

9. Have you ever had an Impairment Rating/ *alguna vez ha tenio una calificacion de impedimento*? ☐ No ☐ Yes

If yes, what is the rating/ *En caso afirmativo, cual es la calificación*? _____

10. Do you have any Permanent Restrictions/ *tiene alguna restriccion permanente*? ☐ No ☐ Yes. If yes, list/ *Si si, lista*:

Patient Name: _____ Date of Birth: _____ Date: _____

PERSONAL ATTESTATION ***ATESTACIÓN PERSONAL***
I certify that the above information is accurate and complete. I understand that inaccurate, false or misleading information may invalidate the examination. I understand that the results of this examination will be shared with my employer and that inaccurate information may interfere with my employment. *Por lo tanto certifico que la Información proporcionada arriba es correcta y verdadera. Yo entiendo que información falsa, o enganosa puede invalidar esta examinación. Yo entiendo que los resultados de este examen serán compartidos con mi empleador, y cualquier información enganosa puede interferir.* Patient Signature /*Firma de paciente*: _____ Date/ Fecha: _____

Section 2. Examination *(to be filled out by medical provider)*

Sección 2. Examen *(debe ser completado por un proveedor medico)*

PATIENT TESTING
***Height**: _____ ***Weight**: _____ ***Pulse Rate**: _____ ***Pulse Rhythm Regular**: ☐ Yes ☐ No ***Blood Pressure**: _____ **BP 2nd Reading** *(if necessary)* _____ ***Vision** *(Snellen)*: Acuity / Uncorrected / Corrected Right Eye (OD) 20/ 20/ Left Eye (OS) 20/ 20/ Both Eyes (OU) 20/ 20/ **Whisper Test** *(must perceive whispered voice at not less than 5 feet in order to pass whisper test)*: ☐ Pass ☐ Fail **Hearing aids**: ☐ Right Ear ☐ Left Ear ☐ None Needed **Audiogram** *(if necessary)*: **Urinalysis** *(if required)*: Specific Gravity _____ Protein _____ Blood _____ Sugar _____ **Blood Glucose** *(if required)*: _____ Fasting: ☐ Yes ☐ No

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Examination *(to be filled out by medical provider)*
Examen *(debe ser completado por un proveedor medico)*

PATIENT HEALTH HISTORY REVIEW

Review and discuss pertinent patient answers and available medical records. Comment on patients "health history" questions that may affect the patient's ability to safely perform their reported job functions.

_____

_____

_____

_____

PHYSICAL EXAM

1. General *(no acute distress)* ..... ☐ Normal ☐ Abnormal
2. Skin *(warm/dry/no acute rash noted)* ..... ☐ Normal ☐ Abnormal
3. Eyes *(no discharge, no icterus)* ..... ☐ Normal ☐ Abnormal
4. Ears ..... ☐ Normal ☐ Abnormal
5. Mouth/Throat ..... ☐ Normal ☐ Abnormal
6. Cardiovascular *(RRR w/o gallup/mumor/rubs)* ..... ☐ Normal ☐ Abnormal
7. Lungs/Chest *(CTA/clear to auscultation)* ..... ☐ Normal ☐ Abnormal
8. Abdomen *(soft, non-tender, non-distended)* ..... ☐ Normal ☐ Abnormal
9. Genito-urinary system ..... ☐ Normal ☐ Abnormal ☐ N/A _____
10. Hernia check *(if applicable)* ..... ☐ Normal ☐ Abnormal ☐ N/A _____
11. Back/Spine ..... ☐ Normal ☐ Abnormal
12. Extremities/Joints *(full range of motion w/out pain)* ..... ☐ Normal ☐ Abnormal
13. Neurological system ..... ☐ Normal ☐ Abnormal
14. Gait ..... ☐ Normal ☐ Abnormal
15. Vascular System *(no swelling, pitting, or edema)* ..... ☐ Normal ☐ Abnormal

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the patient's ability to safely perform their reported job functions. Enter applicable item number before each comment.

_____

_____

_____

_____

_____

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Exam Result ***(to be filled out by medical provider)***
Resultado del examen ***(debe ser completado por un proveedor medico)***

MEDICAL PROVIDER DETERMINATION

Type of Examination: ☐ Initial/PrePlacement ☐ Periodic/Follow-up ☐ Exit ☐ Fit-For-Duty/Return to Work

☐ Other: _____

Clearance:

☐ Patient **DOES** meet medical standards and is cleared for full duty without any restrictions

☐ Patient **DOES** meet medical standards but with restrictions (see notes)

☐ Patient **DOES NOT** meet medical standards and is not medically cleared for duty (see notes)

☐ Exam is on **HOLD** (see notes)

Notes: _____

_____

I have performed this medical examination and have discussed the results of this physical examination with the patient. I attest that to the best of my knowledge, I believe it to be true and correct.

Medical Provider Name *(please print)* _____

Medical Provider Signature _____ Date _____

OSHA Respirator Clearance (OSHA Physicals ONLY)

☐ No limitations on respirator use ☐ Patient is NOT cleared for respirator use

☐ Recommended limitations on use of respirator: ☐ Limit use to 2 hours per day ☐ Emergency Use ONLY

☐ Other limitations or notes: _____

Next Periodic Evaluation: ☐ 1 year ☐ 2 year ☐ 3 year ☐ Other: _____

Medical Provider Signature _____ Date _____

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Patient Name: _____ Date of Birth: _____ Date: _____

WRITTEN MEDICAL REPORT FOR EMPLOYEE – OSHA PHYSICAL ONLY

Type of Examination: ☐ Initial ☐ Periodic ☐ Other: _____

Results of Examination:

Physical Examination	☐ Normal	☐ Abnormal (see below)	☐ Not Performed
Chest X-Ray	☐ Normal	☐ Abnormal (see below)	☐ Not Performed
Spirometry	☐ Normal	☐ Abnormal (see below)	☐ Not Performed
Tuberculosis	☐ Normal	☐ Abnormal (see below)	☐ Not Performed
Other: _____	☐ Normal	☐ Abnormal (see below)	☐ Not Performed

Results reported as abnormal: _____

_____

Your health may be at risk if the following recommendations are not adhered to.

Recommendations:

☐ No limitations on respirator use
☐ Recommended limitations on use of respirator: _____
☐ Recommended limitations on exposure to: _____
☐ I recommend that you be examined by a Board-Certified Specialist in Pulmonary Disease or Occupational Medicine
☐ I recommend that you be examined by your Primary Care Practitioner
☐ I recommend that you be examined by a specialist in the field of: _____
☐ Other recommendations: _____

Notes: _____

_____

*These findings may not be related to respirable crystalline silica exposure or other substances or may not be work-related, and therefore may not be covered by the employer. These findings may necessitate follow-up treatment by your personal physician.

Medical Provider Signature _____ Date _____

AUTHORIZATION FOR OSHA OPINION TO EMPLOYER – OSHA PHYSICAL ONLY

This medical examination for exposure to crystalline silica or other potential substances or workplace exposure could reveal a medical condition that results in recommendations for (1) limitations on respirator use, (2) limitations on exposure to crystalline silica or other substances, or (3) examination by a specialist in pulmonary disease or occupational medicine. Recommended limitations on respirator use will be included in the written opinion to the employer. If you want your employer to know about limitations on crystalline silica or other substances or recommendations for a specialist examination, you will need to give authorization for the written opinion to the employer to include both one or both of those recommendations.

I hereby authorize the opinion to the employer to contain the following information, if relevant (check all that apply):

☐ Recommendations for limitations on crystalline silica exposure
☐ Recommendations for limitations on other substance exposure. List: _____
☐ Recommendations for a specialist examination
OR
☐ I do not authorize the opinion to the employer to contain anything other than recommended limitations on respirator use.

Patient must read and sign: I understand that if I do not authorize my employer to receive the recommendation for specialist examination, the employer will not be responsible for arranging and covering costs of a specialist examination under the OSHA standard for respirable crystalline silica or other substances.

Name (print): _____ Signature: _____ Date: _____