

Medical History and Examination for
Coal Mine Workers' Pneumoconiosis

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: 04-30-05
1. Name and Address		2. DOL Claim No.		4. Date of Exam	
name:					
city: state: zip:		3. Telephone No.		5. Date of Birth	
6. Personal Physician (name, address, phone no.)			7. Examining Physician (name, address, phone no.)		
name:					
city: state: zip:			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 High blood pressure <input type="checkbox"/> <input type="checkbox"/> Heart Disease <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/>	Yes No Asthma <input type="checkbox"/> <input type="checkbox"/> Allergies <input type="checkbox"/> <input type="checkbox"/> Emphysema <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Problems
<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Attacks of wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (of)
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus
<input type="checkbox"/>	<input type="checkbox"/>	Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Bronchial Asthma	<input type="checkbox"/>	<input type="checkbox"/>	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

<input type="checkbox"/> Never Smoked	<input type="checkbox"/> Has Stopped Smoking	<input type="checkbox"/> Currently Smoking
	Started: ; Stopped:	Started:
	Smoked what?	Smokes what?
	How much:	How much:

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
<input type="checkbox"/>	<input type="checkbox"/>	Sputum (daily?)
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing (daily?)
<input type="checkbox"/>	<input type="checkbox"/>	Dyspnea (quantitate)
<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	Hemoptysis
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain (Inciting Factor):
<input type="checkbox"/>	<input type="checkbox"/>	Orthopnea
<input type="checkbox"/>	<input type="checkbox"/>	Ankle edema
<input type="checkbox"/>	<input type="checkbox"/>	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.)

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	Masses	
Personality	Pulsation	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
<input type="checkbox"/> Chest X-ray		
<input type="checkbox"/> Vent Study (PFS)		
<input type="checkbox"/> Arterial Blood Gas		
<input type="checkbox"/> Other:		
<input type="checkbox"/> 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 C-3526, 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.