

C. Patient History (continued) (Please type or neatly print 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 _____
<input type="checkbox"/>	<input type="checkbox"/>	Histoplasmosis _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

b. Other Significant Conditions or Serious Illnesses (and when they were diagnosed):

c. Hospitalizations (reasons and dates):

d. Surgeries:

3. Social History.

a. Smoking History:

Never smoked

Smoked intermittently

Started: _____;
 Stopped: _____;
 Smoked what? _____;
 How much): _____;
 (e.g., packs/day)

Has stopped smoking

Started: _____;
 Stopped: _____;
 Smoked what? _____;
 How much): _____;

Currently smoking

Started: _____;
 Smokes what? _____;
 How much: _____;
 (e.g., packs/day)

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

D. Present Illnesses / 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.)

22. 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, provide a narrative statement listing all findings, especially those pertinent to the respiratory system and the cardiovascular system.

Height:

Weight:

Findings (including pulmonary and respiratory symptoms):

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:		

6. Pulmonary Diagnosis (es) - Provide the basis (es) for your stated diagnosis (es). Attach additional sheets if necessary.

Is this diagnosis supported by the diagnostic tests listed in D5? Please explain how the test results support your diagnosis or explain your rationale for the diagnosis.

7. Etiology of Pulmonary Diagnosis (es): Describe the causes of each pulmonary diagnosis listed above: occupational or environmental exposure, genetic predisposition, smoking, other, or unknown. Describe the contribution of the patient's occupational dust exposure to his/her pulmonary condition. Attach additional sheets if necessary.

8. Disability/Impairment – If the patient has chronic respiratory or pulmonary disease, give your medical assessment – with rationale – of:

- a. The degree of severity of the pulmonary 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.) If you use the AMA Guide to Impairment DO NOT simply cite the impairment class alone, but also provide your reasoned opinion regarding the patient's ability to perform the duties required in his/her last coal mine job. Attach additional sheets if necessary.

Is this disability assessment supported by the diagnostic tests listed in D5? Please explain how the test results support your assessment or explain your rationale for the assessment.

b. The extent to which each of the diagnoses listed in D.6. contributes to this impairment (give your estimate of the percentage or proportion of impairment that can be attributed to each diagnosis (e.g., 50%, substantial, minimal, etc.). Attach additional sheets if necessary.

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

E. Physician Referral

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

F. Physician's 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 imprisonment for up to one year, or both.

Signature: _____

Date: _____

(Physician's name should be typewritten on the 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 composing 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 U.S. Department of Labor, Division of Coal Mine Workers' Compensation, 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 complete this collection of information unless it displays a currently valid OMB control number.