Medical History and Examination for Coal Mine Workers' Pneumoconiosis

Children

U.S. Department of Labor

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 Info	rmation		(* ************************************			DMB No.:1240-0023				
1. Name and	Address			2. DOL Claim No. or SSN			E	Expires: xx-xx-xxxx		
							4.	4. Date of Exam		
				3. Tel	lephone No	0 .	5.	Date of Birth		
6. Personal P	hysician (nam	e, address	, phone no.)		7. Exam	ining Physicia	n (name, ad	dress, phone no	o.)	
					Phone:					
B. Employmer	nt History			(Please type or neatly print all responses.)						
		." Form CN	1-911a or equiva	lent (dat	ted /			se review the form		
								(of at least one		
Then,	move on to "C	. Patient Hi	story."		· ·		•		•	
_										
CM-9	11a is not attac	hed – com	plete both sectio	ns 1. an	d 2. below.					
								job of at least o		
). (Inclu	ide in all lii	nes any coal n	nine constru	ction or transpo	ortation work,	
or work in	a mine prepar	ation iaciii	ity.)							
Name	e of Company		Job Title and I	Descript	ion of Job's	Physical Requ	irements	From	То	
a. Last CME held at least one year.			· · · · · · · · · · · · · · · · · · ·			(mm/yy)				
b. Other CME:	b. Other CME:									
c. Additional n	umber of vears	in CME no	t described abov	/e:	yea	ars.				
							ational toxic	nhalant hazard, (describe the	
	der "Job Title a			олросос	a tiro ordirre	an cocap		maan nazara,		
Name of Comp	any	•	Jol	o Title ar	nd Descript	ion		From	То	
								(mm/yy)	(mm/yy)	
C. Patient History (Family – Medical – Social) (Please type or neatly print all responses.)										
1. Family Hist	=									
Have the p	atient's paren	ts, childre	n, or other "blo	od" rela	tives ever	had any of the	following?	(Check all that	apply):	
	High Blood	Heart	ТВ	As	thma	Allergies	Emphysem	a Stroke	Diabetes	
	Pressure	Disease								
Mother										
Father Siblings										
JUNIUS	I	1	1			I	1	1	1	

C. Patient History (continued)		(P	lease type	or neatly print all responses.)	
2. Individual Health / Medical History.					
a. Does the patient have a history of:					
Yes No When manifed Frequent Colds Pneumonia Pleurisy Attacks of wheezing Tuberculosis Chronic bronchitis Bronchial Asthma Histoplasmosis Other Other b. Other Significant Conditions or Serious Illing C. Hospitalizations (reasons and dates):		No Arthritis Heart disease / Pro Allergies Cancer (of Diabetes Mellitus High Blood Pressu Connective Tissue Other Other Other Ten they were diagnosed) re Disease	When manifested	
3. Social History.	.1				
a. Smoking History: ■ Never smoke	α				
	_				
● Smoked intermittently		ed smoking	● Curr	ently smoking	
Started:;	Started:;		Started:;		
Stopped:;_	Stopped:;			what?;	
Smoked what?;		?;		ch::	
How much)::		:	(e.g., packs/day)		
(e.g., packs/day)	,		(* 3 / [**		
b. Other Pertinent Social History (e.g., drug or al	cohol use. stren	uous hobbies):			
D. Present Illnesses / Physical Examination 1. Chief complaints/symptoms - as described by and/or severity of symptoms).		(Ple		r neatly print all responses) , describe frequency, duration,	
Voc. No.	nonto				
Yes No Comm Sputum (daily?) Wheezing (daily?) Dyspnea (quantitate) Cough Hemoptysis Chest pain (inciting factor) Orthopnea Ankle edema Paroxysmal Nocturnal Dyspnea	nents				

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

22. Otl	ner complaints. (Incli	ude here the patie	nt's description of any limitations in physical activities like walking, climbing, and lifting.)
3. Curr	ent treatment (includ	ing medications)):
			Examination, provide a narrative statement listing all findings, especially those pertinent to
	iratory system and the	cardiovascular sy	ystem.
Height:			
Weight:			
Finding	s (including pulmona	ary and respirato	ry symptoms):
5 Sum	mary of diagnostic t	acting in the cn	ace below, check the applicable block(s) next to any test results (including those
			cal exam) which you reviewed and relied upon, at least in part, to base your medical
asse	ssments and conclusi		nose on the next page. Be sure to show the date(s) of each test and summarize the
resu	lts.		
		Dates	Summary of Results
	Chest X-ray		•
п	Chest X-lay		
	Vent Study (PFS)		
	Arterial Blood Gas		
	Other:		
	- Culci.		
ш	Other:		
		1	1

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.
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 peopsean.
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.

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	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? 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 everyone of 20 minutes now recommend to complete this information collection, including the time for regioning
	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.