Medical History and Examination for Coal Mine Workers' Pneumoconiosis

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 Information **(Please type or neatly print all responses.)**

OMB No.:1240-0023
Expires: xx-xx-xxxx

1. Name and Address	2. DOL Claim No. or SSN	4. Date of Exam
	3. Telephone No.	5. Date of Birth

6. Personal Physician (name, address, phone no.)	7. Examining Physician (name, address, phone no.)
	Phone:

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 employers first. In line (a.) describe the last job of at least one year's duration and specify the exertional level of the job. (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 (mm/yy)	To (mm/yy)
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 claimant 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? (Check all that apply):

	High Blood Pressure	Heart Disease	TB	Asthma	Allergies	Emphysema	Stroke	Diabetes
Mother								
Father								
Siblings								
Children								

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
☐	☐	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	_____
☐	☐	Histoplasmosis		☐	☐	Other	
☐	☐	Other		☐	☐	Other	
☐	☐	Other		☐	☐	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**	● ☐ **Has stopped smoking**	● ☐ **Currently smoking**
Started: _____;	**Started: _____;**	**Started: _____;**
Stopped: _____;	**Stopped: _____;**	**Smokes what? _____;**
Smoked what? _____;	**Smoked what? _____;**	**How much: _____:**
How much): _____:	**How much): _____:**	**(e.g., packs/day)**
(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
☐	☐	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.)

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
☐	**Chest X-ray**		
☐	**Vent Study (PFS)**		
☐	**Arterial Blood Gas**		
☐	**Other:**		
☐	**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.