WorkFitMedical
Occupational Health Services

New Patient Welcome Sheet

Date: _____ Time: _____ Appointment Time: _____

WHY ARE YOU HERE TODAY?

Reason: ☐ Urgent Care ☐ Work Injury ☐ Return to Work/Fit for Duty ☐ Occ. Health ☐ Drug Test

Company Name: _____ Self Pay: ☐ Yes ☐ No

What are you here for today? (Reason for Visit) _____

For Work Injury:

Work Related: ☐ Yes ☐ No Date of Injury: _____

Explain **HOW** injury happened and what **BODY PART** was affected:

_____

_____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Social Security: _____

Street Address: _____ Birth Date: _____ Age: _____

City, State, Zip: _____ Primary Phone: _____

Other Address: _____ Secondary Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married DL#: _____

Person to Contact in Case of Emergency: _____ Phone: _____

INSURANCE INFORMATION

Is the insurance carrier responsible for your visit; Your Private Insurance or Your Employer's Worker's Compensation Insurance?

☐ Private Insurance ☐ Employer's Worker's Compensation Insurance

Name of Insurance: _____ Subscriber # or Claim #: _____

Subscriber's Date of Birth (if not patient): _____

For Worker's Compensation Injury:

Employer Name: _____ Employer Address: _____

Employer Phone: _____ Supervisor's Name: _____

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT:

I hereby authorize WorkFit Medical and its staff and providers to examine and treat my condition as the providers deem appropriate and I give authority for those procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount(s) become necessary, I will be responsible for all charges, fees, and attorney fees. I (we) hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient/Guardian: _____ Date: _____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

Consent for
Examination, Treatment, Testing &
Release of Information

I consent to the use or disclosure of my confidential health information by WorkFit Medical, LLC for the purpose of diagnosis or treatment, obtaining payment for services rendered, and conducting operations of WorkFit Medical, LLC. My signature below is evidence of my consent for evaluation, diagnosis, or treatment by WorkFit Medical, LLC.

I understand that I have the right to request a restriction as to how my confidential health information is used or disclosed while providing treatment, payment, or health care operations of the practice. WorkFit Medical, LLC is not required to agree to the restrictions that I may request. However, if WorkFit Medical, LLC agrees to a restriction I request the restriction is binding on WorkFit Medical, LLC and the providers contracted or employed by WorkFit Medical, LLC. I have the right to revoke this consent in writing, at any time, except to the extent WorkFit Medical, LLC has taken action in reliance on this consent.

My confidential health information includes my demographic information provided by me as well as information provided by or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This confidential health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The Notice of Privacy Practices for WorkFit Medical, LLC is provided on the wall in the waiting area. I understand I have a right to review WorkFit Medical, LLC's Notice of Privacy Practice prior to signing the document. The WorkFit Medical, LLC's Notice of Privacy Practice has been provided or offered to me.

The Notice of Privacy Practice describes the types of use and disclosures of my confidential health information that will occur pursuant to treatment, payment, or in the performance of healthcare operations of WorkFit Medical, LLC. This Notice of Privacy Practice also describes my rights and the duties of WorkFit Medical, LLC with respect to my confidential health information. WorkFit Medical, LLC reserves the right to amend the Notice of Privacy Practice at any time. I may obtain a revised copy of Notice of Privacy Practice upon request.

I agree to undergo clinical examination, diagnostic tests, medical treatment, and drug and/or alcohol testing consistent with the accepted standards of care and practice. The information obtained will be used to carry out treatment plans, to determine my fitness for work, or for billing purposes. I understand that the services routinely provided by WorkFit Medical, LLC are not meant to replace medical care provided by my personal healthcare provider. I am granting permission to WorkFit Medical, LLC to release the results of the examination/treatment and drug and/or alcohol results to the company specified above.

Patient Signature: _____ Date: _____

CONSENT TO TREAT A MINOR: YOU MUST HAVE DOCUMENTATION OF GUARDIANSHIP OR CUSTODY PAPERWORK WHEN BRINGING IN A MINOR

I (we) being the parents, guardian, or custodian of the minor being:
Last Name: _____ First Name: _____ M.I.: _____, Age: _____ do hereby request, and direct WorkFit Medical, LLC, its providers, and staff to perform examinations, diagnostic X-Rays, laboratory tests, and any treatment that in their judgement is deemed advisable or is required while said minor child is under care of this office's providers and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I(we) will be personally responsible for payment of them. I (we) hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature: _____ Date: _____

Relationship to Patient: _____ Witness: _____ Date: _____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

WorkFitMedical
Occupational Health Services

Silica Exam Checklist

Employee Name: _____ DOB: _____
Employer Name: _____ Date: _____

Initial Examination	Completed By:
☐ General Consent Form Complete	
☐ Authorization for Crystalline Silica Opinion to Employer	
☐ History Form Complete (Silicosis History Questionnaire)	
☐ Physical Exam Form Complete	
☐ PPD Form Complete	
☐ PFT Completed	
☐ Chest X-Ray (1 View Completed) – Report Received	
☐ Chest X-Ray Read by B-Read Radiologist	
☐ OSHA Respirator Questionnaire	
☐ Medical Report for Employer Sent to the Employer	
Date Sent: _____ ***Must be within 30 days of exam***	
☐ Medical Report for Employee Sent to the Employee	
Date Sent: _____ **Must be within 30 days of exam**	

Periodic Examination	Completed By:
☐ General Consent Form Complete	
☐ Authorization for Crystalline Silica Opinion to Employer	
☐ History Form Complete (Silicosis History Questionnaire)	
☐ Physical Exam Form Complete	
☐ Only if PPD Form Complete	
☐ PFT Completed	
☐ Chest X-Ray (1 View Completed) – Every 3 Years	
☐ Chest X-Ray Read by B-Read Radiologist or ☐ Chest X-Ray Not Performed	
☐ OSHA Respirator Questionnaire	
☐ Medical Report for Employer Sent to the Employer	
Date Sent: _____ ***Must be within 30 days of exam***	
☐ Medical Report for Employee Sent to the Employee	
Date Sent: _____ **Must be within 30 days of exam**	

The Only Paperwork Sent to the Employer is Medical Report for Employer. No other paperwork is sent.

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

Employee Exposure Information
(To Be Completed by Employer Prior to Examination)

Employee Name: _____ Date of Birth: _____
Employer Name: _____

Reason for Exam (Check One): ☑ Pre-Placement ☐ Prior to Assignment ☐ Periodic

Type of Exam (Check One): ☐ Silica Surveillance

Identification of Contaminant: _____

Has Air Monitoring Been Conducted? ☐ Yes ☐ No

Is Exposure Level above or Anticipated to be above PEL? ☐ Yes ☐ No ☐ Unknown

Describe Employee's Duties as they relate to the Employee's Exposure:

List Types of PPE used or to be Used by Employee (i.e. Type of Respirator, Tyvek Suit, Protective Clothing, Etc.):

Respirator Types (Check All That Apply):

☐ Atmosphere Supplying
☐ Continuous Flow
☐ Supplied Air
☐ Air Purifying (Powered)
☐ Air Purifying (Non-Powered)
☐ Adverse Work Conditions (i.e. Temp/Heat Stress, High Places, Humidity, etc.)

Respirator Weight:

☐ Open Circuit SCBA
☐ Closed Circuit SCBA

Level of Work Effort (Check One): ☐ Light ☐ Moderate ☐ Heavy ☐ Strenuous

OSHA mandates that any information from previous medical examinations of the employee that are not otherwise available to the examining physician be forwarded to the examining physician.

This form shall accompany the employee to the examination or it may be faxed to the examination site.

Completed by: _____ Title: _____ Date: _____

Phone #: _____

To Be Completed By The Employer Prior to Examination

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

WorkFitMedical
Occupational Health Services

Silicosis Surveillance History Questionnaire

Patient Name: _____ Date: _____

DOB: _____ Gender: ☐ Male ☐ Female Race: _____

Company: _____

Job Title: _____ Years Exposed to Silica: _____

MEDICAL HISTORY

Allergies: ☐ None ☐ Yes, List: _____

Medications: ☐ None ☐ Yes (List Medications and Reason for Taking Them):

_____

_____

_____

_____

Surgeries/Hospitalizations (since last Silicosis Exam): ☐ None

_____

_____

_____

_____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

WorkFitMedical
Occupational Health Services

Silicosis Surveillance History Questionnaire

Patient Name: _____ Date: _____

Do you have any of the following conditions currently or since the last Silicosis Physical:

LUNG/PULMONARY:

- ☐ Asthma, Wheezing
- ☐ Abnormal Shortness of Breath with Activities or Work
- ☐ Chronic Bronchitis, Emphysema
- ☐ Coughing Up Blood
- ☐ Lung Diseases
  - ☐ TB
  - ☐ Asbestosis
  - ☐ Silicosis
  - ☐ Other _____
- ☐ Chest Surgery or Injury
- ☐ Collapsed Lung

HEART/VASCULAR:

- ☐ Chest Pain
- ☐ Experienced Dizziness or Blackouts
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Seizures, Fainting, or Stroke
- ☐ Rheumatic Fever
- ☐ Other Heart Problems (Please List): _____
- ☐ Blood Abnormalities
- ☐ Bleeding Problems
- ☐ Blood Cancer (Lymphoma, Leukemia, etc.)
- ☐ Anemia Type: _____
- ☐ Blood Transfusions

GASTROINTESTINAL:

- ☐ Difficulty Swallowing
- ☐ Jaundice/Liver Disease (Hepatitis, Cirrhosis, Liver Cancer, etc.)
- ☐ Bleeding from Stomach or Intestines (Not Hemorrhoids)
- ☐ Stomach or Intestinal Ulcers
- ☐ Stomach Problems Type: _____
- ☐ Intestinal Problems Type: _____

URINARY/KIDNEY/BLADDER/PROSTRATE:

- ☐ Bladder Disease/Problems
- ☐ Kidney Disease/Problems
- ☐ Prostrate Problems (Infection, Enlargement, Cancer)
- ☐ Blood in Urine

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

WorkFitMedical
Occupational Health Services

Silicosis Surveillance History Questionnaire

Patient Name: _____ Date: _____

NEUROLOGIC/SPECIAL SENSES (EARS, EYES, SMELL, etc.):

- ☐ Seizures, Fainting, or Stroke
- ☐ Epilepsy (or Fits, Seizures, Convulsions)
- ☐ Frequent Headaches
- ☐ Migraines
- ☐ Extreme Difficulty with Your Hearing
- ☐ Ruptured Ear Drum
- ☐ Tinnitus or Ringing in the ear(s)
- ☐ Wear Glasses ☐ Wear Contacts
- ☐ Visual Problems Not Corrected with Lenses
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Color Blindness
- ☐ Need to Wear Prescription Glasses in a Respirator
- ☐ Hoarseness/Change in Voice

If you wear contacts, have you worn them for 30 days without problems? ☐ Yes ☐ No

ENDOCRINE:

- ☐ Diabetes – Insulin-Dependent
- ☐ Diabetes – Non-Insulin-Dependent
- ☐ Thyroid Problems
- ☐ Reproductive Problems

MUSCULOSKELETAL:

- ☐ Loss of Sensation or Strength
- ☐ Back Problems
- ☐ Joint Injury or Pain
- ☐ Rheumatoid Arthritis
- ☐ Degenerative Arthritis
- ☐ Other Arthritis _____
- ☐ Muscle or Bone Cancers or Tumors

SKIN:

- ☐ Chloracne
- ☐ Skin Cancers
- ☐ Psoriasis, Seborrhea, or Severe Acne
- ☐ Sensitivity to Sunlight
- ☐ Recurrent Rashes

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

Silicosis Surveillance History Questionnaire

Patient Name: _____ Date: _____

OTHER:

- ☐ Problems Related to Heat Stress
- ☐ Epilepsy (or Fits, Seizures, Convulsions)
- ☐ Night Sweats or Fever
- ☐ Recent Weight Gain/Loss
- ☐ Depression
- ☐ Other Illness (Cancer, TB)
- ☐ Recent Abnormal Laboratory Tests
- ☐ History of Alcohol or Drug Problems

TOBACCO USE:

- ☐ Never
- ☐ Current _____ Packs/Cigars per Day for _____ Years
- ☐ Prior _____ Packs/Cigars per Day for _____ Years Year Quit: _____
- ☐ Smokeless

ALCOHOL USE:

- ☐ Never
- ☐ Current _____ Drinks* per week for _____ Years
- ☐ Prior _____ Drinks* per week for _____ Years Year Quit: _____

*(1 "drink" = 1 beer, 4 oz. glass of wine, or 1 oz. liquor)

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

Silicosis Surveillance History Questionnaire

Patient Name: _____ Date: _____

Have you ever been exposed to any of the following since your last HAZMAT evaluation (either on or off the job):
If exposed please place the appropriate symbol in the yes column.
Yes: ☒ = using protective equipment, ☑= without protective equipment, NA =protective equipment not needed

Y	N		Y	N	
☐	☐	Acrylonitrile	☐	☐	Lead
☐	☐	Arsenic	☐	☐	Methylene Chloride
☐	☐	Antimony	☐	☐	Mercury
☐	☐	Asbestos	☐	☐	Nickel
☐	☐	Benzene	☐	☐	Nitrogen Oxides/Sulfur Dioxide
☐	☐	Beryllium	☐	☐	Paints/Solvents
☐	☐	Cadmium	☐	☐	Organochlorine Pesticides[1]
☐	☐	Carbamate Pesticides (Aldicarb, Baygon, Zectran)	☐	☐	Organophosphate Pesticides[2]
☐	☐	Carbon Disulfide	☐	☐	Petroleum Products/Fuels
☐	☐	Carbon Tetrachloride	☐	☐	Phenols/Phenol-Like Resins
☐	☐	Chloroform	☐	☐	Phosgene
☐	☐	Chlorine	☐	☐	Polychlorinated Biphenyls
☐	☐	Chromium	☐	☐	Radioactive Materials
☐	☐	Coal	☐	☐	Silica/Non- Asbestos Substitutes
☐	☐	Coke Ovens	☐	☐	Toluene
☐	☐	Cutting Oils, Coolants	☐	☐	Toxic Waste
☐	☐	Cyanide	☐	☐	Trichlorethylene
☐	☐	Degreasing/Plating	☐	☐	Vinyl Chloride
☐	☐	Dust/Nuisance Dust	☐	☐	Welding, Soldering Fumes
☐	☐	Engine Exhausts	☐	☐	Xylene
☐	☐	Epoxy Resins, Adhesives	☐	☐	Zinc
☐	☐	Excessive Noise	☐	☐	Other – Specify/Describe
☐	☐	Fiberglass			_____
☐	☐	Fluorides (including Hydrogen Fluoride)			
☐	☐	Formaldehyde			
☐	☐	Galvanizing			
☐	☐	Hydrogen Sulfide			
☐	☐	Isocyanates (TDI,MDI)			

[1]= (DDT, Aldrin, Chlordane, Dieldrin, Endrin, Lindane)
[2]=(Diazinon, Dichlorovos, Dimethoate, Trichlorfon, Malathion, Methyl Parathion, Parathion)

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

Silicosis Surveillance History Questionnaire

Patient Name: _____ Date: _____

Have you had overexposure to any chemical or physical agents (noise, radiation, heat, etc.) since your last HAZMAT Evaluation? ☐ No ☐ Yes, please describe:

_____

_____

What type of Personal Protective Equipment (PPE) do you routinely use when dealing with hazardous materials?
(See Next Page for Level Descriptions)

☐ Level A	☐ Level B	☐ Level C	☐ Level D
☐ Respirator	☐ Full Face, Negative Pressure	☐ Half Face, Negative Pressure	☐ PAPR
☐ SCBA	☐ Particle Dust	☐ TB	☐ Hearing Protection
☐ Muffs	☐ Plugs	☐ Both	

☐ Other: _____

Employee Signature: _____
Provider Name: _____

Provider Signature: _____
Date: _____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

Level A. Should be selected when the greatest level of skin, respiratory, and eye protection is required. The following constitute Level A equipment; it may be used as appropriate:

- Positive pressure, full-facepiece self-contained breathing apparatus (SCBA), or positive pressure supplied-air respirator with escape SCBA, approved by the National Institute for Occupational Safety and Health (NIOSH).
- Totally-encapsulating chemical-protective suit.
- Coveralls.*
- Long underwear.*
- Gloves, outer, chemical-resistant.
- Gloves, inner, chemical-resistant.
- Boots, chemical-resistant steel toe and shank.
- Hard hat (under suit).*
- Disposable protective suit, gloves, and boots. (Depending on suit construction, may be worn over totally-encapsulating suit.)

Level B. The highest level of respiratory protection is necessary but a lesser level of skin protection is needed. The following constitute Level B equipment, it may be used as appropriate:

- Positive pressure, full-facepiece self-contained breathing apparatus (SCBA), or positive pressure supplied-air respirator with escape SCBA (NIOSH approved).
- Hooded chemical-resistant clothing (overalls and long-sleeved jacket, coveralls, one or two-piece chemical-splash suit, disposable chemical-resistant overalls).
- Coveralls.*
- Gloves, outer, chemical-resistant.
- Gloves, inner, chemical-resistant.
- Boots, outer, chemical-resistant steel toe and shank.
- Boot-covers, outer, chemical-resistant (disposable).*
- Hard hat.
- Face shield.*

Level C. The concentration(s) and type(s) of airborne substance(s) is known and the criteria for using air purifying respirators are met. The following constitute Level C equipment, it may be used as appropriate:

- Full-face or half-mask, air purifying respirators (NIOSH approved).
- Hooded chemical-resistant clothing (overalls; two-piece chemical-splash suit; disposable chemical resistant overalls).
- Coveralls.*
- Gloves, outer, chemical-resistant.
- Gloves, inner, chemical-resistant.
- Boots (outer), chemical-resistant steel toe and shank.*
- Boot-covers, outer, chemical-resistant (disposable).*
- Hard hat.
- Escape mask.*
- Face shield.*

Level D. A work uniform affording minimal protection: Used for nuisance contamination only. The following constitute Level D equipment, it may be used as appropriate:

- Coveralls.
- Gloves.*
- Boots/shoes, chemical-resistant steel toe and shank.
- Boots, outer, chemical-resistant (disposable).*
- Safety glasses or chemical splash goggles.*
- Hard hat.
- Escape mask.*
- Face shield.*

*Optional, as applicable.

WorkFitMedical
Occupational Health Services

Respiratory
Fitness Questionnaire

Are you able to read? (Check One): ☐ Yes ☐ No

Part A. Section 1 (Mandatory):

Instructions: Every employee who has been selected to use any type of respirator must provide the following information: (Please Print)

Today's Date: _____
Name: _____
Age: _____ Date of Birth: _____
Sex: ☐ Male ☐ Female
Height: _____ ft. _____ in. Weight: _____ lbs.
Job Title: _____
Social Security Number: _____
Phone Number: _____

Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No

Type of Respirator: ☐ N, R, or P Disposable Respirator ☐ Other: _____
Have you ever worn a respirator? ☐ Yes ☐ No If Yes, What Types: _____

Part A. Section 2 (Mandatory):
Instructions: Questions 1-9 below must be answered by every employee who has been selected to use any type of respirator (Check Yes or No)

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month? ☐ Yes ☐ No
2. Have you **ever had** any of the following conditions?
   a. Seizures (fits): ☐ Yes ☐ No
   b. Diabetes (sugar disease): ☐ Yes ☐ No
   c. Allergic reactions that interfere with your breathing: ☐ Yes ☐ No
   d. Claustrophobia (fear of closed-in places): ☐ Yes ☐ No
   e. Trouble smelling odors: ☐ Yes ☐ No
3. Have you **ever had** any of the following pulmonary or lung problems?
   a. Asbestosis: ☐ Yes ☐ No
   b. Asthma: ☐ Yes ☐ No
   c. Chronic Bronchitis: ☐ Yes ☐ No
   d. Emphysema: ☐ Yes ☐ No
   e. Pneumonia: ☐ Yes ☐ No
   f. Tuberculosis: ☐ Yes ☐ No
   g. Silicosis: ☐ Yes ☐ No
   h. Pneumothorax (collapsed lung): ☐ Yes ☐ No
   i. Lung Cancer: ☐ Yes ☐ No
   j. Broken Ribs: ☐ Yes ☐ No
   k. Any chest injuries or surgeries: ☐ Yes ☐ No
   l. Any other lung problems that you've been told about: ____ Yes ____ No

WorkFitMedical
Occupational Health Services

Respiratory
Fitness Questionnaire

Name: DOB:

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of Breath: ☐ Yes ☐ No
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline? ☐ Yes ☐ No
   c. Shortness of breath when walking with other people at an ordinary place on level ground: ☐ Yes ☐ No
   d. Have to stop for breath when walking at your own pace on level ground ☐ Yes ☐ No
   e. Shortness of breath when washing or dressing yourself: ☐ Yes ☐ No
   f. Shortness of breath that interferes with your job: ☐ Yes ☐ No
   g. Coughing that produces phlegm (thick sputum): ☐ Yes ☐ No
   h. Coughing that wakes you early in the morning: ☐ Yes ☐ No
   i. Coughing that occurs mostly when you are lying down: ☐ Yes ☐ No
   j. Coughing up blood in the last month: ☐ Yes ☐ No
   k. Wheezing: ☐ Yes ☐ No
   l. Wheezing that interferes with your job: ☐ Yes ☐ No
   m. Chest pain when you breathe deeply: ☐ Yes ☐ No
   n. Any other symptoms that you think may be related to lung problems: ☐ Yes ☐ No
5. Have you **ever had** any of the following cardiovascular or heart problems?
   a. Heart attack: ☐ Yes ☐ No
   b. Stroke: ☐ Yes ☐ No
   c. Angina: ☐ Yes ☐ No
   d. Heart Failure: ☐ Yes ☐ No
   e. Swelling in your legs or feet (not caused by walking): ☐ Yes ☐ No
   f. Heart Arrhythmia (heart beating irregularly): ☐ Yes ☐ No
   g. High Blood Pressure: ☐ Yes ☐ No
   h. Any other heart problem that you've been told about: ☐ Yes ☐ No
6. Have you **ever had** any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest: ☐ Yes ☐ No
   b. Pain or tightness in your chest during physical activity: ☐ Yes ☐ No
   c. Pain or tightness in your chest that interferes with your job: ☐ Yes ☐ No
   d. In the past two years, have you noticed your heart skipping or missing a beat: ☐ Yes ☐ No
   e. Heartburn or indigestion that is not related to eating: ☐ Yes ☐ No
   f. Any other symptoms that you think may be related to heart or circulation problems: ☐ Yes ☐ No
7. Do you **currently** take medication for any of the following problems?
   a. Breathing or lung problems: ☐ Yes ☐ No
   b. Heart Trouble: ☐ Yes ☐ No
   c. Blood Pressure: ☐ Yes ☐ No
   d. Seizures (fits): ☐ Yes ☐ No

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-2526 Fax

WorkFitMedical
Occupational Health Services

Respiratory
Fitness Questionnaire

Name: DOB:

8. If you've used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator, check the following box and go to question 9): ☐
    a. Eye Irritation: ☐ Yes ☐ No
    b. Skin Allergies or Rashes: ☐ Yes ☐ No
    c. Anxiety: ☐ Yes ☐ No
    d. General Weakness or Fatigue: ☐ Yes ☐ No
    e. Any other problem that interferes with your use of a respirator: ☐ Yes ☐ No
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: ☐ Yes ☐ No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you **ever lost** vision in either eye (temporarily or permanently): ☐ Yes ☐ No
11. Do you **currently** have any of the following hearing problems?
    a. Wear contact lenses: ☐ Yes ☐ No
    b. Wear glasses: ☐ Yes ☐ No
    c. Color Blind: ☐ Yes ☐ No
    d. Any other eye or vision problem: ☐ Yes ☐ No
12. Have you **ever had** an injury to your ears, including a broken ear drum: ☐ Yes ☐ No
13. Do you **currently** have any of the following hearing problems?
    a. Difficulty Hearing: ☐ Yes ☐ No
    b. Wear a hearing aid: ☐ Yes ☐ No
    c. Any other hearing or ear problem: ☐ Yes ☐ No
14. Have you **ever had** a back injury: ☐ Yes ☐ No
15. Do you **currently** have any of the following musculoskeletal problems?
    a. Weakness in any of your arms, hands, legs, or feet: ☐ Yes ☐ No
    b. Back pain: ☐ Yes ☐ No
    c. Difficulty fully moving your arms and legs: ☐ Yes ☐ No
    d. Pain or stiffness when you lean forward or backward at the waist: ☐ Yes ☐ No
    e. Difficulty fully moving your head up or down: ☐ Yes ☐ No
    f. Difficulty fully moving your head side to side: ☐ Yes ☐ No
    g. Difficulty bending at your knees: ☐ Yes ☐ No
    h. Difficulty squatting to the ground: ☐ Yes ☐ No
    i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: ☐ Yes ☐ No
    j. Any other muscle or skeletal problem that interferes with using a respirator: ☐ Yes ☐ No

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-2526 Fax

WorkFitMedical
Occupational Health Services

Respiratory
Fitness Questionnaire

Name: DOB:

16. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: ☐ Yes ☐ No

    If "Yes" name the chemicals if you know them: _____
    _____
    _____

17. Have you ever worked with any of the materials, or under any of the conditions, listed below:
    a. Asbestos: ☐ Yes ☐ No
    b. Silica (e.g., in sandblasting): ☐ Yes ☐ No
    c. Tungsten/Cobalt (e.g., grinding or welding this material): ☐ Yes ☐ No
    d. Beryllium: ☐ Yes ☐ No
    e. Aluminum: ☐ Yes ☐ No
    f. Coal (for example, mining): ☐ Yes ☐ No
    g. Iron: ☐ Yes ☐ No
    h. Tin: ☐ Yes ☐ No
    i. Dusty Environments: ☐ Yes ☐ No
    j. Any other hazardous exposures: ☐ Yes ☐ No

    If "Yes" describe these exposures: _____
    _____

18. List any second jobs or side businesses you have: _____
_____
_____

19. List your previous occupations/jobs: _____
_____
_____

20. List your current and previous hobbies: _____
_____
_____

21. Have you been in the military services? ☐ Yes ☐ No

If "Yes", were you exposed to biological or chemical agents (either in training or combat): ☐ Yes ☐ No

22. Have you ever worked on a HAZMAT team? ☐ Yes ☐ No
23. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): ☐ Yes ☐ No

If "Yes" name the medications if you know them: _____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-2526 Fax

WorkFitMedical
Occupational Health Services

Respiratory
Fitness Questionnaire

Name: DOB:

24. Will you be using any of the following items with your respirator(s)?
    a. HEPA Filters: ☐ Yes ☐ No
    b. Canisters (for example, gas masks): ☐ Yes ☐ No
    c. Cartridges: ☐ Yes ☐ No

25. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:
    a. Escape only (no rescue): ☐ Yes ☐ No
    b. Emergency rescue only: ☐ Yes ☐ No
    c. Less than 5 hours **per week**: ☐ Yes ☐ No
    d. Less than 2 hours **per day**: ☐ Yes ☐ No
    e. 2 to 4 hours per day: ☐ Yes ☐ No
    f. Over 4 hours per day: ☐ Yes ☐ No

26. During the period you are using the respirator(s), is your work effort:
    a. **Light** (less than 200 kcal per hour): ☐ Yes ☐ No

    If "Yes", how long does this period last during the average shift: _____ hrs. _____ min.

    Examples of a light work effort are **sitting** while writing, typing, drafting, or performing light assembly work; or **standing** while operating a drill press (1-3 lbs.) or controlling machines.

    b. **Moderate** (200 to 350 kcal per hour): ☐ Yes ☐ No

    If "Yes", how long does this period last during the average shift: _____ hrs. _____ min.

    Examples of moderate work effort are **sitting** while nailing or filing; **driving** a truck or bus in urban traffic; **standing** while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; **walking** on a level surface about 2 mph or down a 5-degree grade about 3 mph; or **pushing** a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

    c. **Heavy** (above 350 kcal per hour): ☐ Yes ☐ No

    If "Yes", how long does this period last during the average shift: _____ hrs. _____ min.

    Examples of heavy work are **lifting** a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; **shoveling; standing** while bricklaying or chipping castings; **walking** up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.)

27. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using the respirator: ☐ Yes ☐ No

    If "Yes" describe this protective clothing and/or equipment: _____
    _____
    _____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-2526 Fax

WorkFitMedical
Occupational Health Services

Respiratory
Fitness Questionnaire

Name: DOB:

28. Will you be working under hot conditions (temperature exceeding 77 ° F): ☐ Yes ☐ No

29. Will you be working under humid conditions: ☐ Yes ☐ No

30. Describe the work you'll be doing while you're using your respirator(s): _____
_____
_____

31. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example: confined spaces, life-threatening gases): _____
_____
_____

32. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of Toxic Substance: _____
Estimated Maximum Exposure Level per Shift: _____
Duration of Exposure per shift: _____

Name of Toxic Substance: _____
Estimated Maximum Exposure Level per Shift: _____
Duration of Exposure per shift: _____

Name of Toxic Substance: _____
Estimated Maximum Exposure Level per Shift: _____
Duration of Exposure per shift: _____

Name of Toxic Substance: _____
Estimated Maximum Exposure Level per Shift: _____
Duration of Exposure per shift: _____

Name of Toxic Substance: _____
Estimated Maximum Exposure Level per Shift: _____
Duration of Exposure per shift: _____

33. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example: rescue, security): _____
_____
_____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-2526 Fax

WorkFitMedical
Occupational Health Services

Respiratory
Fitness Questionnaire

Name: DOB:

34. In your present job, are you working at high altitudes (over 5,000 ft.) or in a place that has lower than normal amounts of oxygen: ☐ Yes ☐ No

If "Yes", do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: ☐ Yes ☐ No

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-2526 Fax

WorkFitMedical
Occupational Health Services

Silicosis Examination Form

Employer: _____ Date: _____
Employee: _____ DOB: _____

Years in Surveillance Program: _____

General Health: ☐ Poor ☐ Fair ☐ Good Height: _____ Weight: _____

VISION:

Distance: Left: _____ Right: _____ Both: _____ ☐ Corrected ☐ Uncorrected

HEARING:

☐ Whisper Test Left: _____ Right: _____

VITAL SIGNS:

Blood Pressure: _____ Pulse: _____ ☐ Regular ☐ Irregular

RESPIRATORY HISTORY AND SYMPTOMS: ☐ No Significant History ☐ Positive History

If Positive History, Explain: _____

List any Current Medications: _____

List Any Allergies: _____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

WorkFitMedical
Occupational Health Services

Silicosis Examination Form

			Description of Abnormal Findings
DERMATOLOGICAL			
Granulomata	☐ WNL	☐ Abnormal	
Rash	☐ No	☐ Abnormal	
Pallor	☐ No	☐ Abnormal	
Discoloration	☐ No	☐ Abnormal	
CARDIOVASCULAR SYSTEM			
Rate & Rhythm	☐ WNL	☐ Abnormal	
S1, S2	☐ WNL	☐ Abnormal	
Murmur	☐ No	☐ Yes	
Gallop, Rub	☐ No	☐ Yes	
Peripheral Cyanosis	☐ No	☐ Yes	
Central Cyanosis	☐ No	☐ Yes	
Peripheral Edema	☐ No	☐ Yes	
RESPIRATORY SYSTEM			
Inflation	☐ WNL	☐ Abnormal	
A-P Diameter	☐ WNL	☐ Abnormal	
Percussion	☐ WNL	☐ Abnormal	
Wheezing	☐ No	☐ Abnormal	
Crackles	☐ No	☐ Abnormal	
Dyspnea	☐ No	☐ Abnormal	
GASTROINTESTINAL			
Inspection	☐ WNL	☐ Abnormal	
Bowel Sounds	☐ WNL	☐ Abnormal	
Palpation	☐ WNL	☐ Abnormal	
Percussion	☐ WNL	☐ Abnormal	
MUSCULOSKELETAL			
Joint Tenderness	☐ No	☐ Yes	
Joint Edema	☐ No	☐ Yes	
Joint Crepitus	☐ No	☐ Yes	
Joint Deformity	☐ No	☐ Yes	
IMMUNE			
Oral Ulcerations	☐ No	☐ Yes	
Xerostomin	☐ No	☐ Yes	
Xerophthalmia	☐ No	☐ Yes	

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

WorkFitMedical
Occupational Health Services

Silicosis Examination Form

Visual/Palpable Cancer Screens (Suspicious Findings or History)

_____

_____

_____

_____

_____

_____

_____

Tests:

☐ PFT Results – See Attached Form

☐ Chest X-Ray B-Read Results – See Attached Form

☐ PPD Results – See Attached Form

Provider Name: _____

Provider Signature: _____ Date: _____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

Authorization for
Crystalline Silica Opinion to Employer

This medical examination for exposure to crystalline silica could reveal a medical condition that results in recommendations for (1) limitations on respirator use, (2) limitations on exposure to crystalline silica, 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 exposure or recommendations for a specialist's examination, you will need to give authorization for the written opinion to the employer to include one or both those recommendations.

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

☐ Recommendations for limitations on crystalline silica exposure

☐ 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.

Please read and initial:

_____ 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 cost of a specialist examination.

Patient Name: _____

Patient Signature: _____

Company Name: _____

Date: _____

Form Not to Be Released to Employer – Internal Use Only

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

WorkFitMedical
Occupational Health Services

Medical Report for Employer

Employee Name: _____ Date of Birth: _____
Employer Name: _____ Date of Exam: _____

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

USE OF RESPIRATOR:

☐ No Limitations on Respirator Use
☐ Recommended Limitations on Use of Respirator: _____

_____

Dates of Recommended Limitations, if applicable _____ to _____
MM/DD/YY MM/DD/YY

The employee has provided written authorization for disclosure of the following to the employer (if applicable):

☐ This employee should be examined by an American Board Certified Specialist in Pulmonary Disease or Occupational Medicine.
☐ Recommended limitations on exposure to respirable crystalline silica:

_____

NEXT PERIODIC EVALUATION: ☐ 3 Years Other: _____
MM/DD/YY

☐ I attest that the results have been explained to the employee.

The following is required to be checked by the physician or other Licensed Health Care Professional (PLHCP):

☐ I attest that this medical examination has met the requirements of the medical surveillance section of the OSHA Respirable Crystalline Silica Standard 1910.1053(h) or 1926.1153(h)

Examining Provider: _____ Date: _____

Provider Name: _____
Office Address: _____
Office Phone: _____

Form Must Be Sent to Employer

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax

WorkFitMedical
Occupational Health Services

Medical Report for Employee

Employee Name: _____ Date of Birth: _____
Date of Exam: _____
Employee Address: _____

TYPE OF EXAMINATION:
☐ Initial Examination ☐ Periodic Examination ☐ Specialist Examination ☐ Other: _____

RESULTS OF MEDICAL 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
Test for Tuberculosis:	☐ Normal	☐ Abnormal (See Below)	☐ Not Performed

Other: _____

Results Reported as Abnormal:

_____

_____

☐ Your health may be at increased risk from exposure to respirable crystalline due to the following:

_____

_____

Recommendations:
☐ No limitations on Respirator Use
☐ Recommended Limitations on Use of Respirator _____
☐ Recommended limitations on exposure to Respirator Crystalline Silica: _____

_____

Dates of Recommended Limitations, if Applicable: _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

☐ I recommend that you be examined by a board certified specialist in Pulmonary Disease or Occupational Medicine

☐ Other Recommendations: _____

_____

_____

Your next periodic examination for silica exposure should be in: ☐ 3 Years ☐ Other: _____

Examining Provider Signature: _____ Date: _____

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

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

178 Washington Avenue
Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-0769 Fax