OSHA Physical

WorkFitMedical
Occupational Health Services

Patient Name:________________________________ DOB:___________________ Age:___________

Please complete this page for all types of OSHA Physicals.

Gender: ☐ Male ☐ Female ☐ Non-Binary

Smoking History: ☐ Current Smoker ☐ Former Smoker ☐ Non-smoker

Respiratory History or Symptoms: ☐ No Significant History ☐ Positive History
If Positive, please explain: ____
____
____

List any Current Medications: ____
____
____

List Any Allergies:____
____
____

Which OSHA physical(s) are you here for today?

☐ Respirator ☐ HAZWOPER ☐ Asbestos ☐ Silica ☐ Lead ☐ Other________

For Office Use Only

Height:_______ inches Weight:_______ pounds BMI:_______

Blood Pressure:______/______ Pulse:_______ O2 Sat:_______

Vision:

Right: _______ Left:_______ Both:_______ Corrective Lenses? ☐ Yes ☐ No

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OSHA Physical

Name:______________________________ DOB:______________

If Respirator Physical, please complete this section. If not, skip and move to next section.

Spirometry Interpretation:

☐ Normal ☐ Mild/Mod Obstruction ☐ Low Vital Capacity

FVC:________ FEV1: ________ FEV1/FVC: ________

Comments:____

If HAZWOPER Physical, please complete this section. If not, skip and move to next section.

Spirometry Interpretation:

☐ Normal ☐ Mild/Mod Obstruction ☐ Low Vital Capacity

FVC:________ FEV1: ________ FEV1/FVC: ________

Comments:____

EKG:

☐ Completed Interpretation: ______________________________

Audiogram:

☐ Completed
☐ Normal Avg Loss <40 dB
☐ Abnormal Avg Loss > 40 dB

Frequency (Hz)	Left	Right
500		
1000		
2000		
3000		
4000		
6000		
8000		

If Asbestos Physical, please complete this section. If not, skip and move to next section.

Spirometry Interpretation:

☐ Normal ☐ Mild/Mod Obstruction ☐ Low Vital Capacity

FVC:________ FEV1: ________ FEV1/FVC: ________

Comments:____

Date of last Chest X-Ray B-Read: ___________ ☐ None

Length of time working with Asbestos: ______________ Patients age:__________

Do you need a B-Read?

Initial Physical? Always need B-Read
Less than 10 years of exposure? Every 5 years regardless of patient age
10+ years of exposure? Under **35** years old every 5 years. **35-45** years old every 2 years. **45+** every year.

Chest X-Ray B-Read required? ☐ Yes ☐ No

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OSHA Physical

Name:______________________________ DOB:______________

If Silica Physical, please complete this section. If not, skip and move to next section.

Spirometry Interpretation:

☐ Normal ☐ Mild/Mod Obstruction ☐ Low Vital Capacity

FVC:________ FEV1: ________ FEV1/FVC: ________

Comments:____

Date of last Chest X-Ray B-Read: ___________ ☐ None

Do you need a B-Read?

Initial Physical? Always need B-Read
Over 20 years of exposure or Positive x-ray of silicosis? Annual regardless of patient age
All other Recertification: Every 3 years

Chest X-Ray B-Read required? ☐ Yes ☐ No

Length of time working with Silica: _____________

PPD Required? ☐ Yes ☐ No
Initial Physical? Always need PPD
Over 20 years of exposure or Positive x-ray of silicosis? Annual PPD

Does the examination reveal any abnormalities in the following:

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

Visual/Palpable Cancer Screens (Suspicious findings or history)
____
____
____
____

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Does the examination reveal any abnormalities in the following:

	Yes	No		Yes	No
General Appearance	☐	☐	Neck	☐	☐
Gait	☐	☐	Shoulder (L/R)	☐	☐
Posture	☐	☐	Elbow (L/R)	☐	☐
Skin	☐	☐	Wrist (L/R)	☐	☐
HEENT	☐	☐	Hand (L/R)	☐	☐
Jaw/Dentures	☐	☐	Back	☐	☐
Pulmonary	☐	☐	Hip (L/R)	☐	☐
Cardiovascular	☐	☐	Knee (L/R)	☐	☐
Abdomen	☐	☐	Ankle/Foot (L/R)	☐	☐
GU (Hernia?)	☐	☐	Other:__________	☐	☐
Neurologic	☐	☐			

The following OSHA physical(s) were completed today:

☐ Respirator ☐ HAZWOPER ☐ Asbestos ☐ Silica ☐ Lead ☐ Other_______

This individual is medically qualified to wear a respirator as per CRF Title, 1910.134 ☐ Yes ☐ No

If physically able, the following restrictions are needed:

☐ Removal of facial hair ☐ Must use corrective lenses for adequate vision

☐ Other:____

☐ Full Clearance is pending negative Chest X-Ray B-Read

☐ Physically not qualified to wear a respirator due to the following medical condition(s): ______________________

____

Plan:

☐ Routine follow-up ☐ Early follow up (when/why)__________________________

☐ Follow up with personal physician (when/why)__________________________________

Provider name: ____ Date:__________________

Provider Signature:____

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