OSHA Physical

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
Name:_____ DOB:_____

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WorkFitMedical
Occupational Health Services

OSHA Physical

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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OSHA Physical

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Does the examination reveal any abnormalities in the following:

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

General Appearance	☐	☐	Neck	☐	☐		
Skin	☐	☐					
Hand (L/R)	☐	☐					
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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