

**AVERA WORTHINGTON SPECIALTY CLINICS
GENERAL EMPLOYEE PHYSICAL**

Patient Name: Carlos Ortiz Fonseca DOB: 11/09/77 DATE: 1-18-08

Physical Exam: Wt 171 Ht 63" B/P 106/60 P 72 T 98.7

General Appearance:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Head:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Eyes:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Distance Vision R <u>20/20</u>	L <u>20/20</u>	with/ <u>without</u> corrective lenses Both <u>20/20</u>
Titmus Vision Color <u>Pass</u>	<u>Fail</u>	
Ears:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Nose:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Mouth/Teeth:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Throat:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Neck:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Chest/Lungs:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Heart Vascular:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Abdomen:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Skeletal:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Lymphoid:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Skin:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

PERI: L 70%
R 70%

*No show
PFT on
2/24/08 - Needs
to be done -*

UPPER EXTREMITY:

Inspection:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Strength testing:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Abductor pollicis brevis:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Opponens pollicis:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Shoulder range of motion:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

SPINE:

Inspection:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Range of motion:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

LOWER EXTREMITIES:

Inspection:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Heel/Toe walk strength:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Proximal strength:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Deep tendon reflex symmetry:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Achilles:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Patellar:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Knee:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Collateral stability, Lachman's:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Inflammation or effusion:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

AudiScope™ Screening Results 40db HL 25db HL 20db HL

Patient _____ Tested by _____ Date _____



Welch Allyn

4341 State Street Road
P.O. Box 220
Skaneateles Falls, NY 13153-0220
USA

Y = Response	N = No Response				
Right Ear					
Left Ear					
		500	1000	2000	4000
		Frequency (Hz)			

20

Form 56230 Rev. D

Yes No - Able to perform functions of attached job description.

Physician's Signature: Rd Admin Date: 1/18/08

I authorize the release of my records from this visit to my employer.

Carlos Ortiz
(Patient Signature) _____ (Date)



RESPIRATOR MEDICAL RECOMMENDATION

Name: Carlos Ortiz Ponceca

SSN: 582-57-0570

Based on review of OSHA Respirator Health Questionnaire this individual is:

 Medically approved for all respirators with the exception of SCBA, subject to fit testing.

Based on interview, physical examination and further evaluation as appropriate, this individual is:

 Medically approved for all respirators including SCBA, subject to fit testing.

 Medically approved for only the following type(s) of respirator(s), subject to fit testing.

 Dust Mask

 Negative pressure

 Powered air purifying

 Supplied air

 Self-contained breathing apparatus (SCBA)

 Employee may decline respirator-requiring assignments for temporary health related difficulties.

 Respirator assignment must not be for IDLH (Immediate Danger to Life or Health) environments.

 Employees should not be expected to perform rescue duty or serve as a member of a rescue team. If able to wear a respirator at the time, then rescue duties may be performed.

 Requires further medical information/evaluation prior to qualifying for respirator use.

 Other recommendations and suggested accommodations:

Recommended time period for next exam:

1 year

2 years

5 years

Employee had been provided with a copy of this written recommendation:

Yes

No

X _____

=====URINALYSIS=====

#5-007 01-18-08
Color: Yellow
Clarity: Clear
GLU Negative
BIL Negative
KET Negative
SG 1.020
pH 7.0
PRO Negative
URO 0.2 EU/dL
NIT Negative
BLO Negative
LEU Negative

Body fluid source:

WBC ((200/mm3)
Crystals (Absent)
Sed Rate 4(0-16) F(0-20)mm/hr
Retic Count (0.6 - 1.5%)

=====CHEMISTRY=====

BUN (0 - 100 mg/ml)
Hgb A1C (3.0 - 6.0%)
Lead ((10 ug/dl)
Microalbumin:
Albumin ((37 mg/L)
Creatinine ((16 - 500 mg/dl)
A/C Ratio ((16 mg/dl)

3 Hr. Glucose Tolerance Tests

Fasting Glucose
1/2 Hr. Glucose
1 Hr. Glucose
2 Hr. Glucose
3 Hr. Glucose

=====COAGULATION=====

Bleeding Time (2.0 - 9.5 min.)
Protime (9.6 - 10.8 sec.)
INR
PTT (24 - 33 sec.)

=====IMMUNOLOGY=====

H. Pylori (Negative)
HCG Serum (Negative)
HCG Urine (Negative)
Mono Test (Negative)
RA Screen (Negative)
RA Titer (Negative)

=====MICROBIOLOGY=====

Giardia Antigen (Negative)
Ova & Parasites (None Seen)
RSV (Negative)
Stool for Fat
Stool for WBC
Strep Screen
Influenza A (Negative)
Influenza B (Negative)

=====NORMALS=====

BIL - Neg NIT - Neg SG - 1.000-1.030
BLO - Neg PRO - Neg URO - 0.2-1.0
KET - Neg LEU - Neg
PH - 5-8

=====MICROSCOPIC=====

RBC/hpf
WBC/hpf
CASTS/hpf
SPITH
MUCOUS THREAD
BACTERIA
AMOR, URATES
AMOR, PHOSPHATES
CRYSTALS
YEAST
TRICHOMONAS
OTHER
HANGING DROP
FLUERY
KOH
OCCULT BLOOD
POST VAS CHECK

** REPRINT ** REPRINT **

PAT .00 DIAGNOSIS CODES

1/18/08 730 CARLOS ORTIZFONSECA LS LAB ONLY

INS .00 "FIRST DX MUST MATCH FIRST LINE OF DICT."

TX: 6012453 1083 DOCTOR AVERA WORTHINGTON SPE 110977 30

LHP: 1.

4X: 0015271WC CARLOS ORTIZFONSECA 507 343 0260 SUONEIER NO

EDC: 2.
3.
4.

1711 30 HWY 75 PIPSTONE MN 56164

Reasons: SUZLON

SUZLON ROTOR CO

UA DRUG SCREEN & UA

.00 .00 .00 .00 .00 2 3 0

JESUS TO INTER DVN



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Regulations (Standards - 29 CFR)

**OSHA Respirator Medical Evaluation Questionnaire (Mandatory). -
1910.134 App C**

← [Regulations \(Standards - 29 CFR\) - Table of Contents](#)

- **Part Number:** 1910
- **Part Title:** Occupational Safety and Health Standards
- **Subpart:** I
- **Subpart Title:** Personal Protective Equipment
- **Standard Number:** 1910.134 App C
- **Title:** OSHA Respirator Medical Evaluation Questionnaire (Mandatory).

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:

Can you read (circle one): Yes/No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date: 1/18/08
2. Your name: Carlos Ortiz Fonseca
3. Your age (to nearest year): 30 years old
4. Sex (circle one): Male Female
5. Your height: 5' ft. 3" in.
6. Your weight: 140 lbs.
7. Your job title: _____

Handwritten initials/signature

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): (507) 727-0024

9. The best time to phone you at this number: morning

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

11. Check the type of respirator you will use (you can check more than one category):

a. _____ N, R, or P disposable respirator (filter-mask, non- cartridge type only).

b. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s): _____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "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 problem that you've been told about: Yes/No

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 pace 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

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 space 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 No

11. Do you **currently** have any of the following vision problems?

- a. Wear contact lenses: Yes/No No
- b. Wear glasses: Yes/No No
- c. Color blind: Yes/No No
- d. Any other eye or vision problem: Yes/No No

12. Have you **ever had** an injury to your ears, including a broken ear drum: Yes/No No

13. Do you **currently** have any of the following hearing problems?

- a. Difficulty hearing: Yes/No No
- b. Wear a hearing aid: Yes/No No
- c. Any other hearing or ear problem: Yes/No No

14. Have you **ever had** a back injury: Yes/No 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 No
- b. Back pain: Yes/No No
- c. Difficulty fully moving your arms and legs: Yes/No No
- d. Pain or stiffness when you lean forward or backward at the waist: Yes/No No
- e. Difficulty fully moving your head up or down: Yes/No No
- f. Difficulty fully moving your head side to side: Yes/No No
- g. Difficulty bending at your knees: Yes/No No
- h. Difficulty squatting to the ground: Yes/No No
- i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No No
- j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) 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

2. 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 No

If "yes," name the chemicals if you know them: _____

3. 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: _____

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

5. List your previous occupations: _____

6. List your current and previous hobbies: _____

7. 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

8. Have you ever worked on a HAZMAT team? Yes/No

9. 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: _____

10. 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

11. 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

12. During the period you are using the respirator(s), is your work effort: N/A

a. **Light** (less than 200 kcal per hour): Yes/No

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

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. _____ mins.

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. _____ mins.

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.).

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

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

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s): N/A

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

18. 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): N/A

Name of the first toxic substance: _____
 Estimated maximum exposure level per shift: _____
 Duration of exposure per shift: _____
 Name of the second toxic substance: _____
 Estimated maximum exposure level per shift: _____
 Duration of exposure per shift: _____
 Name of the third toxic substance: _____
 Estimated maximum exposure level per shift: _____
 Duration of exposure per shift: _____
 The name of any other toxic substances that you'll be exposed to while using your respirator: _____

19. 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): N/A

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998]

[Next Standard \(1910.134 App D\)](#)

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