Concentra Medical Centers (TN)
1719 Gallatin Road MADISON, TN 37115
Phone: (615) 870-0143 Fax: (615) 870-5524

Service Date: 04/01/2016

Audiometric Examination Record

Patient: Hickman, Edward L.
SSN: XXX-XX-8568
DOB: 09/01/1948
Gender: M
Address: 3036 Meadowview Ct
CROSS PLAINS, TN 37049
Phone: (615) 379-5002

Employer: Corporate Management Group
Address:
Auth. by:

Contact: Cathy Scholl
Role:
Phone: (303) 920-1425 **Ext.:**
Fax:

RESULTS:

- __ Baseline - yes _____ no _____
- ✓ Audiogram is acceptable
- __ Evidence of high frequency hearing loss on the _____ left and/or _____ right
- __ Evidence of hearing loss in the speech range: on the _____ left and/or _____ right
- __ Standard threshold shift noted
- __ Recommend repeat audiogram within 30 days
- __ Ear protection necessary at 85db. Employee informed.
- __ Employee advised to followup with his/her physician.

Comments: _____

CONCENTRA

DATE: 04/01/16
TIME: 09:12:46

PATIENT:8568

CURRENT AUDIOGRAM

FREQ.	L/DB	R/DB
1000 HZ	00	-05
500 HZ	00	00
V1000 HZ	00	-05
2000 HZ	00	00
3000 HZ	30	05
4000 HZ	30	20
6000 HZ	45	15
8000 HZ	35	15
AVG 2,3,4	020.0	008.3

TEST ID:6421901040610273

ELAPSED TIME = 05:02

TEST TYPE = BASELINE
TEST MODE = PULSED
M = MANUALLY TESTED FREQ

TREMETRICS RA500
SERIAL NUMBER...01900273
SOFTWARE REV. 1.16D-9912
CALIBRATION: 02/04/16
CAL. ANSI 1969,89

PATIENT:8568

X_____

EXAMINER:AM

X_____

AFFIX AUDIOMETRIC RESULTS HERE:

LEFT EAR		RIGHT EAR	
500			500
1K			1K
2K			2K
3K			3K
4K			4K
6K			6K
8K			8K

Hearing Loss Formula: $\frac{500\text{-}1000\text{-}2000\text{-}3000}{4}$ - 25 x 1.5

_____ Audiometer make & serial no._____
__ Calibration date:_____
__ Technician signature:_____

_____
Signature of physician

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MEDICAL HISTORY (ANTECEDENTES MEDICOS)

Have you ever had:
(Ha tenido o padecido alguna vez de:)

Mumps (Paperas)	Yes	No
Measles (Measles)	Yes	No
Diabetes (Diabetes)	Yes	No
High Fever (Fiebres Altas)	Yes	No
Meningitis (Meningitis)	Yes	No
High blood pressure (Alta Presión)	Yes	No
Allergies (Alergias)	Yes	No
Ear infections (Infecciones en los oidos)	Yes	No
Perforation of ear drum (Perforación del timpano)	Yes	No
Drainage from ear (Secreciones en los oidos)	Yes	No
Ringing in ears (Campaneo en los oidos)	Yes	No
Dizziness (Mareos)	Yes	No
Severe head injury (Algun golpe severo en la cabeza)	Yes	No
Arthritis (Artritis)	Yes	No
Recent sinus problems (Problemas recientes con su nariz)	Yes	No
Diagnosed hearing loss (Se la ha diagnosticado de perdida de oir)	Yes	No
Wear a hearing aid (Usa dispositivo auditivo)	Yes	No

NON-OCCUPATIONAL HISTORY (ANTECEDENTES NO LABORALES)

Have you been exposed to:
(Ha estado alguna vez expuesto a:)

Loud music (Musica muy alta)	Yes	No
Power tools (Herramientas de alta potencia)	Yes	No
Motorcycles (Motocicletas)	Yes	No
Gun fire (Disparos de armas)	Yes	No
Military service (Servicio Militar)	Yes	No

If yes, what branch_____
(Si su respuesta fue afirmativa, en que lugar)

OCCUPATIONAL HISTORY (ANTECEDENTES LABORALES)

Use hearing protection Yes No
(Ha usado alguna vez protección para oidos
Plugs _____ Muffs _____
(Tapones) (Orejeras)
Exposed to noise within the last 14 hrs? Yes No
(Ha estado expuesto al ruido durante las ultimas 14 horas?)

OTOSCOPIC EVALUATION (if conducted):

	LEFT	RIGHT
Ear canal clear	Yes ✓ No __	Yes ✓ No __
Ear drum visible	Yes ✓ No __	Yes ✓ No __
Inflammation/Obstruction	Yes __ No ✓	Yes __ No ✓
Scarring of ear drum	Yes __ No ✓	Yes __ No ✓
Drainage from ear	Yes __ No ✓	Yes __ No ✓

E. Hickman
Employee signature (Firma de empleado)

4/1/2016
Date

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CROSS PLAINS, TN 37049
Phone: (615) 379-5002

Employer: Corporate Management Group
Address:

Job Title:
Dept: _____

Race: ASIAN (Asiatico) BLACK (negro) HISPANIC (Hispano) INDIAN (Indio) WHITE (blanco) OTHER (otro)

Highest Grade Completed: B.S.

What work will you be doing? (Job Title/Description): SAW OPERATOR
(Que trabajo hará? (ocupación/descripción))

Have you done this type of work before? (Ha hecho este tipo de trabajo ántes?) Yes ✓ No ____
If so, did you have problems? (Tuvo problemas?) Yes ____ No ✓
Will you be able to do this job? (Podrá hacer este trabajo?) Yes ✓ No ____ Uncertain ____

OCCUPATIONAL HISTORY (ANTECEDENTES LABORALES)

Previous Employer (Empleos Previos)	Job Title (Puesto)	Date(s) (Fecha(s))
Avis Budget	DRIVER	9-2014 — 4-2016
City of W.H.	DIRECTOR PW	8/2006 — 1-2011
PLC	ENGINEER	8/2002 - 8/2006

Y (N) Have you ever been off work for more than one day due to job-related illness or injury?
(Ha faltado usted a su trabajo por más de un diá por enfermedad o por haber sufrido algún accidente?)
If yes, when _____
(Si contestó afirmativamente, especifique)

(Y) N Have you ever been hospitalized?
(Ha estado usted hospitalizado?)
If yes, when 2005 BROKEN WRIST
(Si contestó afirmativamente, especifique)

Have you had exposure to: (Ha estado usted expuesto a:) When

Y (N) Asbestos	(Asbestos)	____
Y (N) Biological Fluids	(Liquidos biologicos)	____
Y (N) Coal	(Fluidos)	____
Y (N) Cotton Dust	(Residuos de algodón)	____
Y (N) Epoxy Resins	(Resinas)	____
(Y) N Foundry Work	(Trabajo de fondas)	1966
Y (N) Fumes/Vapors (gas)	(Humos/Vapores)	____
Y (N) Heavy metals/Mining	(Metales Pesados/Minas)	____
Y (N) Heavy dusts	(Polvo Pesado)	____
Y (N) Loud noise	(Ruidos altos)	____
Y (N) Pesticides	(Pesticidas)	____
Y (N) Solvents/Degreasers	Disolventes/Desengrasars)	____
Y (N) Vibration	(Vibraciones)	____
(Y) N Welding/Soldering	(Soldaduras)	1990
Y N Other (Otros)		

PERSONAL HABITS (HABITOS PERSONALES)

Y (N) Do you smoke cigarettes now?
(Usted fuma?)
Packs per day: ____ Years: ____
(Cuantas cajetillas diarias?) (Hace cuantos anos?)

(Y) N Have you smoked in the past?
(Ha fumado antes?)
When did you quit? 1976
(Cuando dejo usted de fumar?)

Y (N) Do you use chewing tobacco or snuff?
(Mastica o inhala tabaco?)
___ Times per day ____ Years
(Cuantas veces al dia?) (Hace cuantos anos?)

Y (N) Do you drink alcohol?
(Consume usted bebidas alcoholicas?)
___ Drinks per week
(Cuantas por semana)

Y (N) Do you use illegal drugs?
(Consume estupefacientes?)
List (Liste): _____

(Y) N Do you exercise for 30 minutes three times a week or more?
(Hace ejercicio por 30 minutos tres veces por semana o más?)

MEDICATIONS (MEDICAMENTOS)

(Y) N Do you take prescription medication?
(Está tomando algún medicamento prescrito?)
List (Liste): LISINOPRIL HCTZ 20-12.5MG
ATORVASTATIN 20MG
COMBIGAN 0.2/0.5%

(Y) N Do you take over-the-counter medication?
(Toma usted medicamentos sin receta medica?)
List (Liste): ALEVE

Y (N) Are you allergic to any medication?
(Es usted alergico a algún medicamento?)
List (Liste): _____

Y N Have you had a tetanus booster in the past five (5) years
(Ha tenido una vacuna de refuerzo para el Tetano en los ultimos cinco años?)

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IMPAIRMENT HISTORY (HISTORIA DE IMPEDIMENTOS)

Do you have

Y (N) Loss of vision in either eye that cannot be corrected?
(Perdida de la vista en cualquier ojo, y que no pueda ser corregida)

Y (N) Loss of hearing that requires a hearing aid?
(Perdida del oido que requiera del uso de un dispositivo auditivo)

Y (N) Decreased function in either hand, including grip and strength and the use of all fingers?
(Disminución en el uso de sus manos, incluyendo su habilidad para apretar y el uso de sus dedos)

Y (N) Decreased function in neck or lower back?
(Disminución en el movimiento del cuello o de su espalda)

Y (N) Decreased function in hips, knees, legs, ankles or feet?
(Disminución en el movimiento de cadera, rodillas, piernas, tobillos o pies)

Do you have any impairments or problems that would interfere with your ability to: (Impedimento que interfiera con su habilidad para:)

Y (N) Work at heights (Trabajar en alturas)
Y (N) Work in cold or heat (Trabajar en zonas frías o calientes)
Y (N) Work around or operate dangerous machinery
(Trabajar cerca de u operar máquinas peligrosas)
Y (N) Drive company vehicles on public highways
(Manejar vehiculos de la compania en carreteras publicas)
Y (N) Work in confined spaces (Trabajar en espacios pequeños)
Y (N) Use a respirator (Usar de un respirador)

REVIEW OF SYSTEMS (Chequiando su Sistema)

Have you ever had or been told you had:
(Ha tenido o le han dicho que tiene:)

Y (N) asthma (asma)
Y (N) serious allergies (graves alergias)
Y (N) back pain (dolor de espalda)
Y (N) bronchitis (bronquitis)
Y (N) carpal tunnel syndrome (sindrome de la muñeca)
Y (N) chest pain (dolor en el pecho)
Y (N) diabetes (diabetes)
Y (N) emphysema (emfísema)
Y (N) epilepsy or other seizure disorders
(epilepsia u otra alteración del control)
Y (N) fainting spells (desmayos)
Y (N) hearing difficulty (dificultad de audición)
Y (N) heart attack (infarto)
Y (N) heart disease (enfermedad del corazón)
Y (N) hepatitis, cirrhosis, or other liver disease
(Hepatitis, cirrosis, o padecimiento del hígado)
(Y) N high blood pressure (presión alta)
Y (N) jaundice (ictericia)
Y (N) musculo-skeletal problems (problemas oseos)
Y (N) neurological problems (problemas neurológicos)
Y (N) nose bleeds (sangramiento por la naríz)
Y (N) shortness of breath (falto de respiración)
Y (N) sleep disorders (padece algún problema para conciliar el sueño)
Y (N) surgery (cirugía)
Y (N) T.B. Positive **(Reacción positiva a tuberculosis)**
Y (N) vision problems (problemas de la vista)
Y (N) wear contacts (uso de lentes de contacto)
(Y) N wear glasses (uso de anteojos)

The above answers are true and correct to the best of my knowledge and belief. I understand that falsification may be grounds for termination.

(Las respuestas dadas por mi son verdades y que han sido contestadas al alcance de mi conocimiento falsificacion a cualesquiera de dichas preguntas podra resultar en despido de mi empleo.)

Applicant's Signature: (Firma del aplicante) E. Hickman Date (Fecha:) 4/1/2016

Provider's Comments: _____

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Name: Hickman, Edward L. **SSN:** XXX-XX-8568 **Date:** 04/01/2016

PHYSICAL EXAM

Height: 71 Weight: 200 Temperature: 97.6 Vision: Uncorrected Corrected Visual Fields

B/P Resting 154/83 Pulse 105 Repeat B/P ____ , ____ Near Rt ____ Near Rt ____ Rt 85 o

(2 min of ex) ____ Pulse ____ Lt ____ Lt ____ Lt 85 o

Respirations/min 110 Distant Rt ____ Distant Rt 30/25 Color (NL) AB

Hearing to forced whisper @ 5 feet Rt ____ Lt ____ Lt 20/30 Depth Perception NL AB

Rt and Lt WNL

HEENT

Eyes
- Globe NL AB
- Pupils NL AB
- EOM's NL AB
- Funduscopic NL AB
- Ocular Pressure:
  - Rt NL AB
  - Lt NL AB

Ears
- Canal Clear Y N
- TM Visualized Y N
- Scarring of TM N Y
- Drainage N Y

Nose NL AB

Mouth
- Teeth NL AB
- Throat NL AB

Skin NL AB

Neck NL AB

Thyroid NL AB

Chest Wall NL AB

Lungs NL AB

Heart
- Rhythm NL AB
- Auscultation NL AB

Abdomen NL AB

Abd. surg. scar N Y

Hernia
- Umbilical N Y
- Inguinal N Y
- Femoral N Y

Varicocele N Y

Upper Extremity NL AB
- Hands/Fingers NL AB
- Legs NL AB
- Knees NL AB
- Knee surg. scar N Y
- Feet/ankles NL AB
- Varicosities NL AB
- Up. ext. strength NL AB
- Up. ext. ROM NL AB
- Low. ext. strength NL AB
- Low. ext. ROM NL AB
- Back/spine ROM NL AB
- Back surg. scar N Y

Neurological Exam:
- Cran. nerves 2-12: NL AB

Reflexes
- Babinski NL AB
- Romberg NEG POS
- Pupillary Rt NL AB
  - Lt NL AB
- Accom. Rt NL AB
  - Lt NL AB
- Biceps Rt NL AB
  - Lt NL AB
- Knee Rt NL AB
  - Lt NL AB
- Ankle Rt NL AB
  - Lt NL AB

Proprioception
- Up. Ext. Rt NL AB
  - Lt NL AB
- Low. Ext. Rt NL AB
  - Lt NL AB

Sensory Examination:
- Up. Ext. Rt NL AB
  - Lt NL AB
- Low. Ext. Rt NL AB
  - Lt NL AB

OPTIONAL:
- Genitalia NL AB
- Breast NL AB
- Rectal NL AB

Comments: ____

ANCILLARY STUDIES

Urinalysis Spec. Gravity: ____ Albumin ____ Sugar ____ Blood ____

EKG N/A NL AB See Results

Comments: ____

Lumbar X-Ray N/A NL AB See Results

Comments: ____

Chest X-Ray N/A NL AB See Results

Comments: ____

Blood Analysis N/A NL AB See Results

Comments: ____

Audiogram N/A NL AB See Results

Comments: ____

HPE NL AB

Comments: ____

Pulmonary Function Test:

FEV1 ___ FVC ____ FEV1/FVC ___

Respirator Qualified? Y N

Comments: ____

Impairment Rating:

Comments: ____

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Examination Results

✓ Able to perform essential functions as listed.

____ Unable to perform all essential functions as listed. Please list failed essential function(s):

✓ No medical restrictions are indicated.

____ The following medical restrictions are indicated:

✓ Recommend further evaluation.

Remarks: Flu 2 pcp for elevated b/p

Brian Lovely
Provider Print Name Here

Provider Signature