AVERA WORTHINGTON SPECIALTY CLINICS
GENERAL EMPLOYEE PHYSICAL

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

Jaime gabriel Cintron 5/14/08
(Patient Signature) *(Date)*
Patient Name: Jaime Cintron Ortiz **DOB:** 5/29/77 **DATE:** 5/14/08
Physical Exam: Wt 171 Ht 5'7 1/4" B/P 140/88 P 76

General Appearance:	✓ Normal	___ Abnormal
Head:	✓ Normal	___ Abnormal
Eyes:	✓ Normal	___ Abnormal
Distance Vision R 20/25	L 20/20 with/	(without) corrective lenses
Holmgrens Color (Pass) Fail		
Ears:	✓ Normal	___ Abnormal
Nose:	✓ Normal	___ Abnormal
Mouth/Teeth:	✓ Normal	___ Abnormal
Throat:	✓ Normal	___ Abnormal
Neck:	✓ Normal	___ Abnormal
Chest/Lungs:	✓ Normal	___ Abnormal
Heart Vascular:	✓ Normal	___ Abnormal
Abdomen:	✓ Normal	___ Abnormal
Skeletal:	✓ Normal	___ Abnormal
Lymphoid:	✓ Normal	___ Abnormal
Skin:	✓ Normal	___ Abnormal

UPPER EXTREMITY:		
Inspection:	✓ Normal	___ Abnormal
Strength testing:	✓ Normal	___ Abnormal
Abductor pollicis brevis:	✓ Normal	___ Abnormal
Opponens pollicis:	✓ Normal	___ Abnormal
Shoulder range of motion:	✓ Normal	___ Abnormal

SPINE:		
Inspection:	✓ Normal	___ Abnormal
Range of motion:	✓ Normal	___ Abnormal

LOWER EXTREMITIES:		
Inspection:	✓ Normal	___ Abnormal
Heel/Toe walk strength:	✓ Normal	___ Abnormal
Proximal strength:	✓ Normal	___ Abnormal
Deep tendon reflex symmetry	✓ Normal	___ Abnormal
Achilles:	✓ Normal	___ Abnormal
Patellar:	✓ Normal	___ Abnormal
Knee:		
Collateral stability, Lachman's:	✓ Normal	___ Abnormal
Inflammation or effusion:	✓ Normal	___ Abnormal

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

Physician's Signature: _____ Date: 05/14/08
SUNDARA C. NALLA, M.D.

Avera
Worthington
Specialty Clinics

RESPIRATOR MEDICAL RECOMMENDATION

Name: Jaime Cintrora Ortiz SSN: _____

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

✓ Medically approved for al 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 maybe 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 _____ 05-14-2008

SUNDARA C. NALLA, M.D.

URINALYSIS

#3-017 05-14-08
Color: Yellow
Clarity: Clear
GLU Negative
BIL Negative
KET Negative
SG 1.020
pH 6.0
PRO Negative
URO 0.2 EU/dL
NIT Negative
BLO Negative
LEU Negative

NORMALS

GLU - Neg NIT - Neg SG - 1.003-1.030
BIL - Neg BLO - Neg URO - 0.2-1.0
KET - Neg LEU - Neg
PRO - Neg pH - 5-8

MICROSCOPIC

RBC/hpf
WBC/hpf
CASTS/pf
EPITH
MUCOUS THREAD
BACTERIA
AMOR, URATES
AMOR. PHOSPHATES
CRYSTALS
YEAST
TRICHOMONAS
OTHER

HANGING DROP

FLUERY
KOH
OCCULT BLOOD
POST VAS CHECK

HEMATOLOGY

Body fluid source:

WBC (<200/mm3)
Crystals (Absent)

Sed Rate M(0-15) F(0-20)mm/hr
Retic Count (0.5 - 1.5%)

CHEMISTRY

BNP (0 - 100 pg/ml)
Hgb A1C (3.0 - 5.0%)
Lead (<10 ug/dl)

Microalbumin:

Albumin (<37 mg/L)
Creatinine (<15 - 500 mg/dl)
A/C Ratio (<15 mg/G)

3 Hr. Glucose Tolerance Tests **08 Guidelines**

Fasting Glucose 95
1/2 Hr. Glucose --
1 Hr. Glucose 180
2 Hr. Glucose 155
3 Hr. Glucose 140

COAGULATION

Bleeding Time (2.3 - 9.5 min.)
Protime (9.5 - 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)

** REPRINT ** REPRINT **
5/14/08 330p JAIME G CINTRONORTIZ PR EXAM/LIMITED

PAT .00 INS .00

DIAGNOSIS CODES
"FIRST DX MUST MATCH FIRST LINE OF DICT."
1.
2.
3.
4.

YX: 6359367 1022 MALLA #0 AVERA WORTHINGTON SPE 052977 30 LMP: EDC:

08-24-32

MX: [illegible] JAIME G CINTRONORTIZ 507 343 1027 MALLA #0

1319 EAST AVE WORTHINGTON MN 56187

.00 .00 .00 .00 .00 1 1 0 HIPAA PRIVACY NOTICE

Reasons: SUZLON DRUG SCREEN AND UA
PFT#1 AT 230 OLIVA INTERP PFT
ONLY, EXAM TO FOLLOW AT 3300#
JESUS WILL DO EXAM OVR
Next Apt. 5/14/08, 230p

SSN Review:

MEK & Associates | **Spirotech Integrity PFT** | **Snellville, GA 30078**

(**SN#:** *7806067 V4M* **Version:** *4.1.0*) Calibration Date: 05/14/2008

Name: **JAIME CINTRON ORTIZ** Test Date: 05/14/2008

ID: 008-24-38 2 Age: 30 Sex: M Technician: R. FUNK Temperature: 21.6 C

Height: 66.0 in Race: Hispanic Physician: NALLA, S Pressure: 760.0 mm Hg

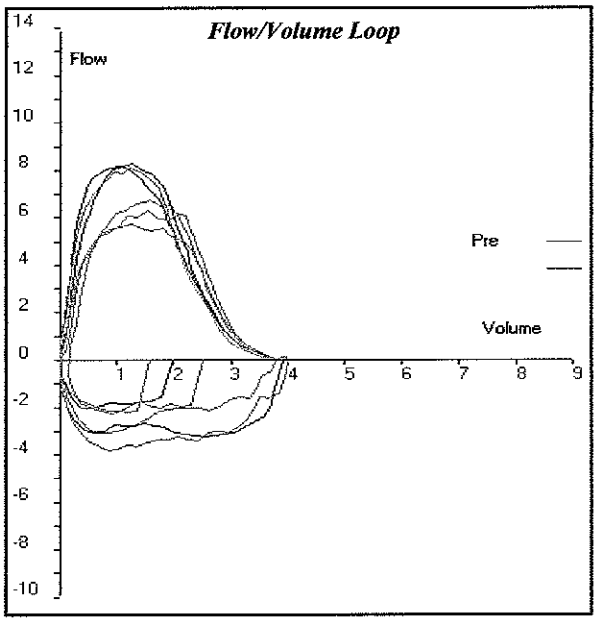
Weight: 172.0 lb BMI: 27.8 BTPS: 1.09

Comments: *SUZLON PRE EMPLOYMENT* Predicted Set: **Knudson-1983**

Pre-Interpretation: Modified **Test Quality:** 5 of 5 **Effort/Position:** Maximal/Sitting **Criteria Met:** Yes

Normal expiratory flows and a normal FVC.SYRINGE VOL. 3.88,MEAS. VOL. 3.84

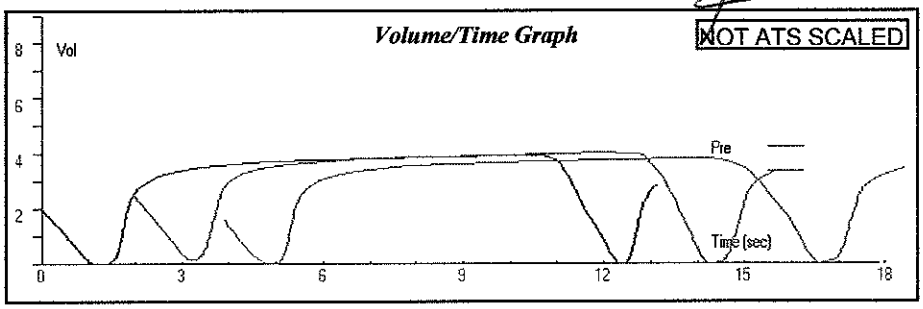
Post-Interpretation: **Test Quality:** 0 of 0 **Effort/Position:** **Criteria Met:** No



Physicians Comments:

Normal study

Physicians Signature: SUNDARA C. NALLA, M.D. 5/14/08



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Height: 66.0 in Race: Hispanic — **Physician:** NALLA, S — **Pressure:** 760.0 mm Hg

Weight: 172.0 lb BMI: 27.8 — **BTPS:** 1.09

Comments: *SUZLON PRE EMPLOYMENT* — **Predicted Set:** **Knudson-1983**

Spirometry

Pre Results

05/14/2008 16:07

Parameter	Predicted	Best: # 5	%Pred
FVC	3.80	3.93	103.36
FEV.5	2.50	2.81	112.19
FEV1	3.19	3.23	101.13
FEV3	3.73	3.68	98.70
PEFR	7.41	8.49	114.61
FEF 25%-75%	3.48	3.93	112.77
FEV1/FVC	0.84	0.82	98.16
FEV3/FVC		0.94	
FET		8.82	
MVV	116.96		

Reproduciblity:	%	Vol	Cmet
FVC (5% / 200 ml)	1.78	0.07	Y
FEV1 (5% / 200 ml)	0.93	0.03	Y
PEFR (15% / 300 ml)	2.36	0.20	Y

NOTICE: DLCo results are based on the following values: Hb = g/dl, *COHb =* g/dl

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: 05-14-08

2. Your name: Jaime Cintron Ortiz

3. Your age (to nearest year): 30

4. Sex (circle one): Male/Female

5. Your height: 5 ft. 4 in.

6. Your weight: 172 lbs.

7. Your job title: _____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): 507 343-1027

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

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): Don't know
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

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

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

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: none

_____

5. List your previous occupations: none

_____

6. List your current and previous hobbies: none

_____

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)? Don't know

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)?: Don't know

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: Don't know

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: 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): Don't know

_____

_____

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

Not Sure

_____

_____

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): Don't know any of this information

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):

_____

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

Next Standard (1910.134 App D)

Regulations (Standards - 29 CFR) - Table of Contents

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Occupational Safety & Health Administration
200 Constitution Avenue, NW
Washington, DC 20210