

**AVERA WORTHINGTON SPECIALTY CLINICS  
GENERAL EMPLOYEE PHYSICAL**

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

*No  
interp  
needed*

*Michael Owens* *1/10/08*  
(Patient Signature) (Date)

Patient Name: *Michael Owens* DOB: *12/23/60* DATE: *1/10/08*

Physical Exam: Wt *244* Ht *72* B/P *152/102* P *64*

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	L <u><i>20/30</i></u>	with/ <u><i>without</i></u> corrective lenses
Holmgrens Color	<u><i>Pass</i></u> Fail	
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

**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:		
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

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

Physician's Signature: *Sundara C. Nalla*

Date: *01-10-2008*

**SUNDARA C. NALLA, M.D.**



Worthington  
Specialty Clinics

RESPIRATOR MEDICAL RECOMMENDATION

Name: Michael Owens SSN: \_\_\_\_\_

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 maybe performed.

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

\_\_\_\_\_ Other recommendations and suggested accommodations:

He was advised to lose some weight for BP control  
Low-salt diet and avoidance of caffeine discussed with  
him. I also recommended 20-30 minutes per day of  
exercise at least five days per week. Follow-up of his elevated  
BP with his doctor in 2-3 Months time.

Recommended time period for next exam:

- 1 year
- 2 years
- 5 years
- \_\_\_\_\_

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

- Yes
- No

X \_\_\_\_\_

SUNDARA C. NALLA, M.D

01-10-2008

=====URINALYSIS=====

#4-013 01-10-08  
Color: Yellow  
Clarity: Clear  
GLU Negative  
BIL Negative  
KET Negative  
SG <=1.005  
pH 6.5  
PRO Negative  
URO 0.2 EU/dL  
NIT Negative  
BLO Negative  
LEU Negative

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 - 6.0%)  
Lead (<10 ug/dl)

Microalbumin:

Albumin ((37 mg/L)  
Creatinine ((15 - 500 mg/dl)  
A/C Ratio ((16 mg/G)

3 Hr. Glucose Tolerance Tests

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

=====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

=====COAGULATION=====

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

=====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

\*\* REPRINT \*\* REPRINT \*\*

1/10/08 430p MICHAEL J OWENS

PR EXAM/LIMITED

PAT .00  
INS .00

DIAGNOSIS CODES

"FIRST DX MUST MATCH FIRST LINE OF DICT."

TX: 6305889 1022 NALLA MD AVERA WORTHINGTON SPE 122360 47

LMP:  
EOC:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

HX: 0814431WC MICHAEL J OWENS

507 372 5114 NALLA MD

X WORTHINGTON MN 56187

Reasons: SUZLOW PHYSICAL  
NO INTERP

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

DVN  
Next Apt. 1/10/08, 330p

(SN#: 7806067 V4M Version: 4.1.0)

Calibration Date: 01/10/2008

Name: MICHAEL OWENS

Test Date: 01/10/2008

ID: 008-14-43 Age: 47 Sex: M

Technician: R. FUNK

Temperature: 22.1 C

Height: 71.0 in Race: African-American

Physician: NALLA, S

Pressure: 760.0 mm Hg

Weight: 240.0 lb BMI: 33.5\*

BTPS: 1.09

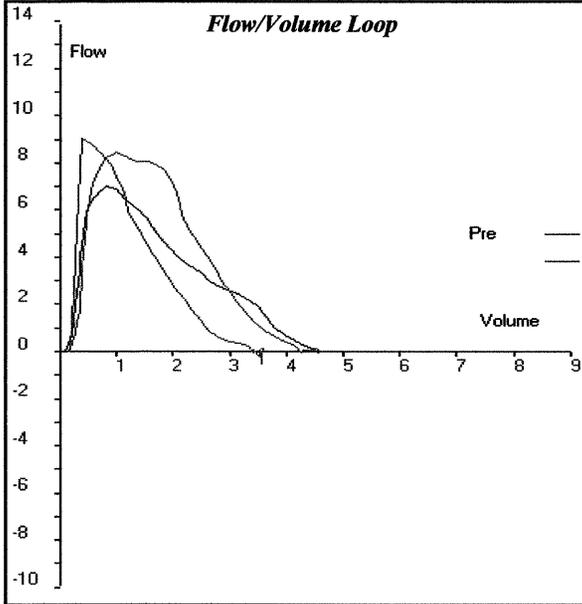
Comments: SUZLON PHYSICAL

Predicted Set: Knudson-1983

Pre-Interpretation: Modified Test Quality: 3 of 3 Effort/Position: Maximal/Sitting Criteria Met: Yes

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

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



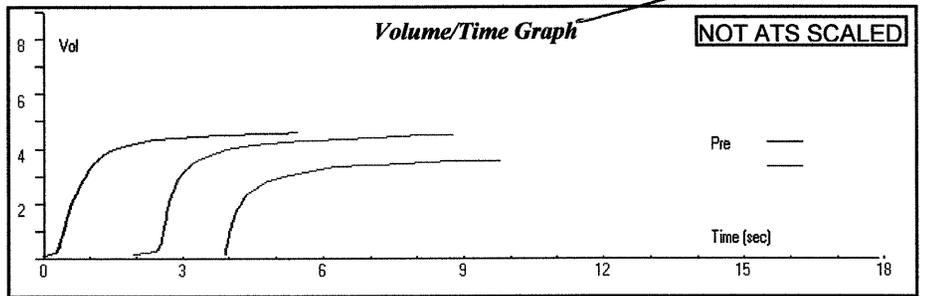
Physicians Comments:

Normal PFT

*[Handwritten Signature]*

Sundara e. Nalla MD  
01-10-2008

Physicians Signature:



(SN#: 7806067 V4M Version: 4.1.0)

Calibration Date: 01/10/2008

Name: MICHAEL OWENS

Test Date: 01/10/2008

ID: 008-14-43

Age: 47

Sex: M

Technician: R. FUNK

Temperature: 22.1 C

Height: 71.0 in

Race: African-American

Physician: NALLA, S

Pressure: 760.0 mm Hg

Weight: 240.0 lb

BMI: 33.5\*

BTPS: 1.09

Comments: SUZLON PHYSICAL

Predicted Set: Knudson-1983

Spirometry

## Pre Results

01/10/2008 14:55

<u>Parameter</u>	<u>Predicted</u>	<u>Best: # 1</u>	<u>%Pred</u>
FVC	4.28	4.51	105.31
FEV.5	2.66	2.97	111.72
FEV1	3.49	3.66	104.88
FEV3	3.96	4.35	109.83
PEFR	7.92	9.58	121.01
FEF 25%-75%	3.59	3.41	95.11
FEV1/FVC	0.82	0.81	99.08
FEV3/FVC		0.96	
FET		5.30	

MVV 118.05

<u>Reproducibility:</u>	<u>%</u>	<u>Vol</u>	<u>Cmet</u>
FVC (5% / 200 ml)	2.88	0.13	Y
FEV1 (5% / 200 ml)	2.19	0.08	Y
PEFR (15% / 300 ml)	9.81	0.94	Y

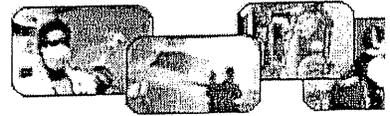
**NOTICE:** DLCo results are based on the following values: Hb = g/dl, COHb = g/dl



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Occupational Safety & Health Administration

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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: 11/10/08
2. Your name: Michael J Owens
3. Your age (to nearest year): 47 yrs 12-23-60
4. Sex (circle one):  Male / Female
5. Your height: 5 ft. 11 1/2 in.
6. Your weight: 225 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): 372-5114

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

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): a couple of types but I don't know the names.

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  
I smoke about 3 sigarets a month.

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  No
- e. Shortness of breath when washing or dressing yourself: Yes/No  No
- f. Shortness of breath that interferes with your job: Yes/No  No
- g. Coughing that produces phlegm (thick sputum): Yes/No  No
- h. Coughing that wakes you early in the morning: Yes/No  No
- i. Coughing that occurs mostly when you are lying down: Yes/No  No
- j. Coughing up blood in the last month: Yes/No  No
- k. Wheezing: Yes/No  No
- l. Wheezing that interferes with your job: Yes/No  No
- m. Chest pain when you breathe deeply: Yes/No  No
- n. Any other symptoms that you think may be related to lung problems: Yes/No  No

5. Have you **ever had** any of the following cardiovascular or heart problems?

- a. Heart attack: Yes/No  No
- b. Stroke: Yes/No  No
- c. Angina: Yes/No  No
- d. Heart failure: Yes/No  No
- e. Swelling in your legs or feet (not caused by walking): Yes/No  No
- f. Heart arrhythmia (heart beating irregularly): Yes/No  No
- g. High blood pressure: Yes/No  No *when I was over weight*
- h. Any other heart problem that you've been told about: Yes/No  No

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

- a. Frequent pain or tightness in your chest: Yes/No  No
- b. Pain or tightness in your chest during physical activity: Yes/No  No
- c. Pain or tightness in your chest that interferes with your job: Yes/No  No
- d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No  No
- e. Heartburn or indigestion that is not related to eating: Yes/No  No
- f. Any other symptoms that you think may be related to heart or circulation problems:  
Yes/No  No

7. Do you **currently** take medication for any of the following problems?

- a. Breathing or lung problems: Yes/No  No
- b. Heart trouble: Yes/No  No
- c. Blood pressure: Yes/No  No
- d. Seizures (fits): Yes/No  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  No
- b. Skin allergies or rashes: Yes/No  No
- c. Anxiety: Yes/No  No
- d. General weakness or fatigue: Yes/No  No
- e. Any other problem that interferes with your use of a respirator: Yes/No  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  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: I was a Welder  
 I never been sick.  I Poured Hot Iron In a factory, Never Sick.

4. List any second jobs or side businesses you have: NO

5. List your previous occupations: Water line, Concrete Sewer Pipe layer.

6. List your current and previous hobbies: Working on Cars

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: INDometHacin for gout.

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)? ~~I don't know~~ Never

- 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

I Haven't Started Working for Company yet

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

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.

X b. Moderate (200 to 350 kcal per hour): Yes/No X

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.

X c. Heavy (above 350 kcal per hour): Yes/No X

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):  
\_\_\_\_\_  
\_\_\_\_\_

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

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):

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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