



Physician's Report of Occupational Pneumoconiosis

Return completed form to:
 BrickStreet Mutual Insurance
 P.O. Box 3151
 Charleston, WV 25332-3151

Claimant's Name (First, Middle, Last)				BrickStreet Use Only			
Claimant's Address							
City, State, Zip							
Date of Birth (Month, Day, Year)		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed				
Date of first treatment or examination (Month, Day, Year)			Diagnosis				
In your opinion has claimant contracted occupational pneumoconiosis? <input type="checkbox"/> Yes <input type="checkbox"/> No							
How long has claimant been suffering from the disease of occupational pneumoconiosis?							
Has the claimant's capacity for work been impaired by occupational pneumoconiosis? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, to what extent?							
History: Has the claimant ever had							
	Yes	No	Date		Yes	No	Date
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		Angina Pectoria	<input type="checkbox"/>	<input type="checkbox"/>	
Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>		Coronary Occlusion	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	
				Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Other serious illnesses <input type="checkbox"/> Yes <input type="checkbox"/> No			Date and describe				
Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No			Date and describe				
Accidents <input type="checkbox"/> Yes <input type="checkbox"/> No			Date and describe				
Present complaints and duration of complaints							
Has the sputum of the claimant been examined for tubercle bacillus? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, by whom?							
What lab?							
Findings?							
Where are the lab reports filed?							
If employee is deceased, was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Has claimant participated in any OP treatment program? <input type="checkbox"/> Yes <input type="checkbox"/> No							

Have x-rays been made of the claimant's lungs? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Right lung <input type="checkbox"/> Yes <input type="checkbox"/> No		Left Lung <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes to either, please answer below.			
Hospital or Doctor	Date	Where Filed	Findings
Have pulmonary function studies, blood gas studies or other pertinent clinical examinations been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please answer below.			
Hospital or Doctor	Date	Where Filed	Findings

Appearance: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Height: ft. in.
Weight: lbs. One year ago: lbs.

Breath Sounds: <input type="checkbox"/> Normal <input type="checkbox"/> Suppressed <input type="checkbox"/> Rales <input type="checkbox"/> Wheezing
Findings:

Heart: Blood Pressure:
Pulse:
Sounds: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Murmurs:
Findings:

Other significant physical abnormalities:

Signature
Address
Date