

Claimant name (first, middle, last)						<b>Encova use only</b>	
Claimant address						Silicosis	
City, state, ZIP						OP	
Date of birth (month, day, year)		<input type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Married	Social Security number		OD
		<input type="checkbox"/> Female	<input type="checkbox"/> Widowed				
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?							
<b>History - Has the claimant ever had</b>							
	<b>Yes</b>	<b>No</b>	<b>Date</b>		<b>Yes</b>	<b>No</b>	<b>Date</b>
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.			
<b>Hospital or doctor</b>	<b>Date</b>	<b>Where filed</b>	<b>Findings</b>
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.			
<b>Hospital or doctor</b>	<b>Date</b>	<b>Where filed</b>	<b>Findings</b>
Appearance <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Height	ft.	in.
Weight	One year ago	lbs.	
Breath sounds <input type="checkbox"/> Normal <input type="checkbox"/> Suppressed <input type="checkbox"/> Rales <input type="checkbox"/> Wheezing			
Findings			
Blood pressure	Pulse		
Sounds <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Murmurs		
Findings			
Other significant physical abnormalities			
Signature			
Address			
Date			