CARDIAC
RESIDUAL FUNCTIONAL CAPACITY
QUESTIONNAIRE

To: _____

Re: _____ (Name of Patient)

_XXX - XX - _____ (Social Security #)

Please answer the following questions concerning your patient's impairments. *Attach all relevant treatment notes, laboratory and test results which have not been provided previously to the Social Security Administration.*

1. Nature, frequency and length of contact:

_____

_____

2. Diagnosis (with New York Heart Association functional classification):_____

_____

3. Identify the clinical findings, laboratory and test results which show your patient's medical impairments:

_____

_____

4. Identify all of your patient's *symptoms:*

__ chest pain __ edema

__ anginal equivalent pain __ nausea

__ shortness of breath __ palpitations

__ fatigue __ dizziness

__ weakness __ sweatiness

Other_____

_____

5. If your patient has anginal pain, describe the frequency, nature, location, radiation, precipitating factors, and severity of this pain: _____

_____

_____

6. Is your patient a malingerer? __ Yes __ No

7. Does your patient have *marked limitation of physical activity*, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though your patient is comfortable at rest?

__ Yes __ No

8. a. What is the role of stress in bringing on your patient's symptoms?

_____

_____

_____

b. To what degree can your patient tolerate work stress?

__ Incapable of even "low stress" jobs
__ Capable of low stress jobs
__ Moderate stress is okay
__ Capable of high stress work

c. Please explain the reasons for your conclusion:

_____

_____

9. Do your patient's physical symptoms and limitations cause emotional difficulties such as depression or chronic anxiety? __ Yes __ No

Please explain:_____

_____

10. Do emotional factors contribute to the severity of your patient's subjective symptoms and functional limitations?

__ Yes __ No

11. How often is your patient's experience of cardiac symptoms (including psychological preoccupation with his/her cardiac condition, if any) severe enough to interfere with attention and concentration?

__ Never __ Seldom __ Often __ Frequently __ Constantly

12. Are your patient's impairments (physical impairments plus any emotional impairments) *reasonably consistent* with the symptoms and functional limitations described in this evaluation?
__ Yes __ No

If no, please explain: _____

_____

13. a. List of prescribed medications:

Name of medication and dosage	**Daily amount taken**
_____	_____
_____	_____
_____	_____

b. Describe any side effects of your patient's medication and identify any implications for working:_____

_____

_____

14. Prognosis:_____

15. Have your patient's impairments lasted or can they be expected to last at least twelve months?
__ Yes __ No

16. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in *a competitive work situation*:

a. How many city blocks can your patient walk without rest?
_____

b. Please circle the hours and/or minutes that your patient can sit *at one time*, e.g., before needing to get up, etc.

Sit: 0 5 10 15 20 30 45
Minutes

1 2 More than 2
Hours

c. Please circle the hours and/or minutes that your patient can stand *at one time,* e.g., before needing to sit down, walk around, etc.

Stand: 0 5 10 15 20 30 45
Minutes

1 2 More than 2
Hours

d. Does your patient need a job which permits shifting positions *at will* from sitting, standing or walking?

__ Yes __ No

e. Will your patient sometimes need to take unscheduled breaks during an 8-hour working shift? __ Yes __ No

If yes, 1) How often do you think this will happen?

_____

2) How long (on average) will your patient have to rest before returning to work?

_____

f. With prolonged sitting, should your patient's leg(s) be elevated?

__ Yes __ No

If yes, 1) How *high* should the leg(s) be elevated?

_____

2) If your patient had a sedentary job, *what percentage of time* during an 8-hour working day should the leg(s) be elevated? _____%

For the next two questions, "rarely" means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.

g. How many pounds can your patient lift and carry in a competitive work situation?

	Never	**Rarely**	**Occasionally**	**Frequently**
Less than 10 lbs.	[ ]	[ ]	[ ]	[ ]
10 lbs.	[ ]	[ ]	[ ]	[ ]
20 lbs.	[ ]	[ ]	[ ]	[ ]
50 lbs.	[ ]	[ ]	[ ]	[ ]

h. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Twist	[ ]	[ ]	[ ]	[ ]
Stoop (bend)	[ ]	[ ]	[ ]	[ ]
Crouch	[ ]	[ ]	[ ]	[ ]
Climb ladders	[ ]	[ ]	[ ]	[ ]
Climb stairs	[ ]	[ ]	[ ]	[ ]

i. State the degree to which your patient should avoid the following:

ENVIRONMENTAL RESTRICTIONS:	NO RESTRICTION	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Extreme cold				
Extreme heat				
Wetness				
Humidity				
Noise				
Fumes, odors, dusts, gases, poor ventilation, etc.				
Hazards (machinery, heights, etc.)				

j. Are your patient's impairments likely to produce "good days" and "bad days?"
__ Yes __ No

If yes, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments or treatment:

[ ] Never
[ ] About one day per month
[ ] About two days per month
[ ] About three days per month
[ ] About four days per month
[ ] More than four days per month

17. Identify any additional tests or procedures you would advise to fully assess your patient's impairments, symptoms and limitations: _____

_____

18. Please describe any other limitations (such as limitations using arms, hands, fingers, psychological limitations, limited vision, difficulty hearing, etc.) that would affect your patient's ability to work at a regular job on a basis:_____

_____

_____

_____

_____

_____
Date

_____
Signature

Printed/Typed Name: _____

Address: _____

_____

Please return to:
Driscoll Salazar Disability Group
8280 Aspen Ave. Ste 155
Rancho Cucamonga, CA 91730
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