PULMONARY

RESIDUAL FUNCTIONAL CAPACITY

QUESTIONNAIRE

To: _____

Re: _____ (Name of Patient)

XXX - XX - _____ (Social Security No.)

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

1. Frequency and length of contact: _____

2. Diagnoses: _____

_____

3. Identify the clinical findings, laboratory and pulmonary function test results that show your patient's medical impairments: _____

_____

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

__ shortness of breath	__ rhonchi	__ episodic pneumonia
__ orthopnea	__ edema	__ fatigue
__ chest tightness	__ episodic acute asthma	__ palpitations
__ wheezing	__ episodic acute bronchitis	__ coughing

Other symptoms: _____

_____

5. If your patient has acute asthma attacks,

   a. Identify the precipitating factors:

   __ upper respiratory infection __ emotional upset/stress

   __ allergens __ irritants

   __ exercise __ cold air/change in weather

   __ aspirin/tartazine __ foods

   b. Characterize the nature and severity of your patient's attacks:

   _____

   _____

   c. How often does your patient have asthma attacks? _____

   d. How long is your patient incapacitated during an average attack? _____

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

7. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? __ Yes __ No

8. 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: _____

9. How often during a typical workday is your patient's experience of pain or other symptoms severe enough to interfere with **attention and concentration** needed to perform even simple work tasks?

   __ Never __ Rarely __ Occasionally __ Frequently __ Constantly

For this and other questions on this form, "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.

10. 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

Please explain the reasons for your conclusion: _____

11. a. List of prescribed medications: _____

_____

_____

_____

_____

b. Describe any side effects of your patient's medications (particularly of steroids, if applicable) that may have implications for working, e.g., dizziness, fatigue, drowsiness, stomach upset, etc.: _____

_____

_____

12. Prognosis: _____

13. Have your patient's impairments lasted or can they be expected to last at least twelve months?

__ Yes __ No

14. 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 or severe pain? _____

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. How long can your patient sit and stand/walk ***total*** *in an 8-hour working day* (with normal breaks)?

Sit	**Stand/walk**	
__	__	less than 2 hours
__	__	about 2 hours
__	__	about 4 hours
__	__	at least 6 hours

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? _____

3) on such a break, will your patient need to __ lie down or __ sit quietly?

f. 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.	__	__	__	__

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

	Never	Rarely	Occasionally	Frequently
Twist	__	__	__	__
Stoop (bend)	__	__	__	__
Crouch/ squat	__	__	__	__
Climb ladders	__	__	__	__
Climb stairs	__	__	__	__

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

ENVIRONMENTAL RESTRICTIONS	**NO RESTRICTIONS**	**AVOID CONCENTRATED EXPOSURE**	**AVOID EVEN MODERATE EXPOSURE**	**AVOID ALL EXPOSURE**
Extreme cold	__	__	__	__
Extreme heat	__	__	__	__
High humidity	__	__	__	__
Wetness	__	__	__	__
Cigarette smoke	__	__	__	__
Perfumes	__	__	__	__
Soldering fluxes	__	__	__	__
Solvents/cleaners	__	__	__	__
Fumes, odors, gases	__	__	__	__
Dust	__	__	__	__
Chemicals	__	__	__	__
List other irritants:				
_____	__	__	__	__

i. 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

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

_____

_____

_____

_____ _____

Date ***Signature***

Printed/Typed Name: _____

Address: _____

_____

_____

Please return to:

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