Residual Functional Capacity Questionnaire
ARTHRITIS

Patient: _____

DOB: _____

Physician completing this form: _____

Please complete the following questions regarding this patient's impairments and attach all supporting treatment notes, radiologist reports, laboratory and test results.

Symptoms & Diagnosis

Does your patient have Meniere's Disease? ☐ Yes ☐ No

What other diagnoses has this patient received? _____

_____

Describe the patient's symptoms, such as pain, dizziness, fatigue, etc._____

_____

_____

Does the patient have chronic pain/paresthesia? ☐ Yes ☐ No

Describe the patient's type of pain, location, frequency, precipitating factors, and severity. _____

_____

_____

Please indicate all positive objective signs exhibited by the patient during a Meniere's attack:

☐ Balance Disturbance (frequent)	☐ Fatigue/Exhaustion	☐ Inability to Concentrate
☐ Malaise	☐ Mental Confusion	☐ Mood Changes
☐ Nausea/vomiting	☐ Photosensitivity	☐ Progressive Hearing Loss
☐ Sensitivity to Noise	☐ Tinnitus	☐ Vertigo
☐ Visual Disturbances	☐ Other: _____	

If the patient has progressive hearing loss, how the hearing loss was diagnosed? _____

Does your patient have disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests? ☐ Yes ☐ No

If no, explain how the absence of vestibular tests or a negative vestibular test affects the diagnosis and assessment of severity of the impairment: _____

_____

_____

What is the average frequency of your patient's Meniere's attacks? _____ per week _____ per month

How long is a typical attack? _____

Does the patient always have a warning of an impending attack? ☐ Yes ☐ No

If yes, how long between the warning and the onset of the attack? _____ minutes

Can the patient take safety precautions when he/she feels an attack coming on? ☐ Yes ☐ No

List any known precipitating factors to an attack: _____

_____

_____

Please indicate postures or positions that are likely to cause vertigo for the patient:

☐ Bending Forward at the Waist ☐ Looking Down
☐ Looking Up ☐ Sitting to Standing
☐ Turning Head to Left/Right ☐ Walking
☐ Other: _____

Please indicate situations that make the patient's attack worse.

☐ Bright lights ☐ Noise
☐ Movement ☐ Other:_____

Please indicate situations that make the patient's attack better.

☐ Cold/Hot Pack ☐ Lying in a Dimly Lit Room
☐ Other:_____

Please indicate post-attack manifestations?

☐ Confusion ☐ Exhaustion
☐ Irritability ☐ Paranoia
☐ Severe headache ☐ Other:_____
How long do these manifestations last? _____

How does an attack interfere with the patient's daily activities?_____

_____

_____

What is the earliest date that the above description of limitations applies? _____

Have these symptoms lasted (or are they expected to last) twelve months or longer? ☐ Yes ☐ No

Are this patient's symptoms and functional limitations impacted by emotional factors? ☐ Yes ☐ No

If yes, please mark any known psychological conditions that affect this patient's pain:

☐ Depression ☐ Anxiety ☐ Somatoform disorder ☐ Personality disorder
☐ Other: _____

Are these physical and emotional impairments reasonably consistent with the patient's symptoms and functional limitations? ☐ Yes ☐ No

If no, please explain: _____

_____

Testing & Treatments

Identify any positive clinical findings and test results: _____

_____

_____

Please list the patient's current medications: _____

_____

Please indicate the treatment type, start dates, and frequency: _____

_____

_____

What is the patient's prognosis? _____

Is this patient a malingerer? ☐ Yes ☐ No

Functional Work Limitations

When answering the following questions, please consider this patient's impairments and estimate his or her ability to work in a competitive work environment for an 8-hour shift with normal breaks.

How often do you expect this patient's pain or symptoms to interfere with the attention and concentration necessary to perform simple work tasks?

- ☐ Never
- ☐ Rarely (1% to 5% of an 8 hour working day)
- ☐ Occasionally (6% to 33% of an 8 hour working day)
- ☐ Frequently (34% to 66% of an 8 hour working day)
- ☐ Constantly

How well do you expect this patient to be able to tolerate work stress?

- ☐ Incapable of even "low stress" jobs
- ☐ Only capable of low stress jobs
- ☐ Moderate stress is okay
- ☐ Capable of high stress situations

Explain: _____

_____

Is this patient taking any medications with side effects that may affect his or her ability to work?

☐ Yes ☐ No

If yes, please list possible side effects. _____

_____

Does this patient require unscheduled breaks during attacks?

☐ Yes ☐ No

If yes, how often? _____

During this time, this patient will need to ☐ lie down ☐ sit quietly for _____ minutes.

Are this patient's impairments likely to produce "good days" and "bad days"?

☐ Yes ☐ No

If yes, please estimate, on 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

Please describe any other limitations that might affect this patient's ability to work at a regular job on a sustained basis, such as psychological issues, limited vision or hearing, or the inability to adjust to temperature, wetness, humidity, noise, dust, fumes, gases or hazards, etc.

_____

_____

_____

Please describe additional tests or clinical findings not described on this form that clarify the severity of the patient's impairments.

_____

_____

_____

Completed by:

_____
Physican's Printed Name

_____
Physician's Signature

_____
Address

_____
Date

_____

_____