

Residual Functional Capacity Questionnaire MYASTHENIA GRAVIS

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 myasthenia gravis? Yes No

If yes, how was this diagnosis made? _____

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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Alteration in voice | <input type="checkbox"/> Breathing difficulty | <input type="checkbox"/> Choking |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Drooping upper eyelid | <input type="checkbox"/> Facial muscle weakness |
| <input type="checkbox"/> General fatigue | <input type="checkbox"/> Limb weakness | <input type="checkbox"/> Muscle fatigue after exercise |
| <input type="checkbox"/> Nasal regurgitation of food | <input type="checkbox"/> Stomach cramping | <input type="checkbox"/> Other: _____ |

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

Do the patient's signs and symptoms fluctuate in intensity over the course of hours or days? Yes No

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:

- | | | | |
|---------------------------------------|----------------------------------|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Somatoform disorder | <input type="checkbox"/> Personality disorder |
| <input type="checkbox"/> 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: _____

Does the patient have significant difficulty speaking, swallowing or breathing even while on prescribed therapy? Yes No

If yes, please describe the degree of difficulty: _____

Does the patient have significant motor weakness of muscles of extremities on repetitive activity against resistance even while on prescribed therapy? Yes No

If yes, please describe the repetitive activity and the severity of the muscle weakness: _____

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. _____

How far can this patient walk without rest or severe pain? _____

How long can this patient sit comfortably at one time before needing to get up?

Minutes: 0 5 10 15 20 30 45

Hours: 1 2 Longer than 2

What must the patient usually do after sitting this long?

Stand Walk Lie Down Other: _____

How long can this patient stand comfortably at one time before needing to sit or walk around?

Minutes: 0 5 10 15 20 30 45

Hours: 1 2 Longer than 2

What must the patient usually do after sitting this long?

Sit Walk Lie Down Other: _____

How long can this patient sit in an 8-hour working day?

less than 2 hours

about 2 hours

about 4 hours

at least 6 hours

How long can this patient stand and/or walk in an 8-hour working day?

less than 2 hours

about 2 hours

about 4 hours

at least 6 hours

Does this patient require a job that allows the opportunity to change between sitting, standing and walking at will? Yes No

Does this patient require unscheduled breaks?

Yes No

If yes, how often? _____

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

With prolonged sitting, should this patient's leg(s) be elevated?

Yes No

If yes, for what percentage of time in an 8-hour day? _____%

During occasional standing/walking, does this patient require a cane or other assistive device?

Yes No

How many pounds can this patient lift and carry?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How often can your patient perform the following activities?

	Never	Rarely	Occasionally	Frequently
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stoop (bend)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does this patient have significant limitations with repetitive reaching, handling or fingering?

Yes No

If yes, please indicate the percentage of time this patient can perform the following activities:

Using hands to grasp, turn and twist objects Right _____% Left _____%
 Using fingers for fine manipulation Right _____% Left _____%
 Using arms to reach out and overhead Right _____% Left _____%

Do the patient's impairments require limited exposure to changes in the environment?

	No Exposure Restriction	Avoid Prolonged Exposure	Avoid Moderate Exposure	Avoid All Exposure
Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extreme Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extreme Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fumes, odors, dusts, gasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perfumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigarette Smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soldering Fluxes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Solvents/Cleaners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 three days per month
 About one day per month About four days per month
 About two 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