

Residual Functional Capacity Questionnaire HEPATITIS C

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 this patient have hepatitis C? Yes No If yes, is the patient symptomatic? 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. _____

Mark all positive objective signs exhibited by the patient:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Anemia | <input type="checkbox"/> Ascites | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Bowel Incontinence | <input type="checkbox"/> Cholangitis | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Concentration Issues |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Diarrhea (recurrent) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Enlarged Liver |
| <input type="checkbox"/> Enlarged Spleen | <input type="checkbox"/> Esophageal Varices | <input type="checkbox"/> Fevers (recurrent) | <input type="checkbox"/> Hematemesis |
| <input type="checkbox"/> Hot/Cold Spells | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Muscular/Joint Aches |
| <input type="checkbox"/> Muscle Wasting | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Peripheral Edema |
| <input type="checkbox"/> Right Upper Quadrant Pain | <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Skin Rashes | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Spider Nevi | <input type="checkbox"/> Tremors | <input type="checkbox"/> Urinary Frequency | |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Other: _____ | |

Does the patient have fatigue? Yes No

If yes, does the degree of fatigue correlate with the severity of hepatitis C or with the degree of elevation of laboratory tests? Yes No

If no, please explain: _____

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: _____

Does this patient take any medications (such as interferon or ribavirin) 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? _____

For which symptoms?

Fatigue Medication Side Effects Nausea Pain/Arthralgia

Other: _____

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? _____%

How high? _____

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"/>

