Residual Functional Capacity Questionnaire
VESTIBULAR DISORDER

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

What 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:
☐ Balance disturbance  ☐ Fatigue/exhaustion  ☐ Malaise
☐ Mental confusion/inability to concentrate  ☐ Mood changes
☐ Nausea/vomiting  ☐ Photosensitivity  ☐ Sensitivity to noise
☐ Tinnitus  ☐ Vertigo  ☐ Visual disturbances
☐ Other_______________________________________

Does the patient have a history of progressive hearing loss?  □ Yes  □ No
If yes, how was the hearing loss established?  □ Audiometry  □ Other: __________________________

Would it be difficult for your patient to understanding oral communications in an environment with constant background noise?  □ Yes  □ No

Does the patient’s 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: __________________________

How often does the patient experience Vestibular symptoms?  _____ times per week  _____ times per month

How long does an attack typically last? ______________________________________________________
Does the patient always have a warning of an impending attack? ☐ Yes ☐ No
If yes, how long is it between the warning and the onset of the attack? _____ minutes

Can the patient always take safety precautions when feeling an attack coming on? ☐ Yes ☐ No

Are there precipitating factors such as stress, exertion, sudden movement, certain kinds of light, computer monitors, etc.? ☐ Yes ☐ No
If yes, explain: ________________________________________________________________

Does the patient exhibit positional vertigo? ☐ Yes ☐ No
If yes, please identify the postures or positions which are likely to cause vertigo:
☐ Bending forward at the waist ☐ Looking down ☐ Looking up
☐ Sitting to standing ☐ Turning head to left/right ☐ Walking
☐ Other: ____________________________

What are post-attack manifestations?
☐ Confusion ☐ Exhaustion ☐ Paranoia
☐ Irritability ☐ Severe headache ☐ Other: ____________________________

How long after an attack do these manifestations last? __________________________

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: ____________________________________________________________________________________

Which aspects of workplace stress is your patient unable to tolerate?

☐ Public contact
☐ Routine, Repetitive Tasks at Consistent Pace
☐ Detailed or Complicated Tasks
☐ Strict Deadlines
☐ Close Interaction with Co-Workers/Supervisors
☐ Fast Paced Tasks, such as a production line
☐ Exposure to Work Hazards, such as heights or moving machinery
☐ Other: ___________________________________________________________________________________

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 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

Might the patient require unscheduled breaks?  □ Yes  □ No
If yes, how many times?  1 2 3 4 5 6 7 8 9 10 >10
For how many minutes? <5 5 10 20 30 45 60 90 >90
For which symptoms?
- Chronic fatigue
- Medication side effects
- Nausea/vomiting
- Dizziness
- Tinnitus
- Other: _______________________

During occasional standing/walking, does this patient require a cane or other assistive device?
□ Yes  □ No
For which symptoms?
- Dizziness
- Other: _______________________

How many pounds can this patient lift and carry?

<table>
<thead>
<tr>
<th>Less than 10 lbs.</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 lbs.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>20 lbs.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>50 lbs.</td>
<td>□</td>
<td>□</td>
<td>□</td>
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</tbody>
</table>

How often can your patient perform the following activities?

<table>
<thead>
<tr>
<th>Twist</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
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</tbody>
</table>

Stoop (bend)

□ □ □ □

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 _____%

What symptoms cause these limitations? _______________________

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.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

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

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

Completed by:

Physician’s Printed Name  Physician’s Signature

Address  Date