

## Residual Functional Capacity Questionnaire VISION IMPAIRMENT

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 describe the patient's vision symptoms:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Please describe the patient's vision:

Visual acuity after best correction right eye: \_\_\_\_\_

Visual acuity after best correction left eye: \_\_\_\_\_

Describe any contraction of peripheral visual fields: \_\_\_\_\_

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Identify any positive clinical findings and test results: \_\_\_\_\_

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Please list the patient's current medications: \_\_\_\_\_

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Please indicate the treatment type, start dates, and frequency: \_\_\_\_\_

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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: \_\_\_\_\_

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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. \_\_\_\_\_

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How often can your patient perform work activities involving the following?

	Never	Rarely	Occasionally	Frequently
Accommodation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depth Perception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Far Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Field of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Near Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is the patient able to:

- Avoiding ordinary hazards in the workplace?  Yes  No
- Walk up or down stairs?  Yes  No
- Work with small objects?  Yes  No
- Work with large objects?  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
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"/>

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.

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Completed by:

\_\_\_\_\_  
Physican's Printed Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Address  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date