CARDIAC
RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE

To:

Re:

SSN: XXX-XX-

Please answer the following questions concerning your patient's impairments. *Attach all relevant treatment notes, laboratory and test results that have not been provided previously to the Social Security Administration.*

1. Frequency and length of contact: ______________________________

2. Diagnosis (with New York Heart Association functional classification): ______________

3. Prognosis: ______________________________

4. Identify the clinical findings, laboratory and test results that show your patient's medical impairments: ______________________________

   ____

5. Identify all of your patient's *symptoms:*

   ___ chest pain   ___ edema   ___ angina equivalent pain
   ___ nausea   ___ fatigue   ___ weakness
   ___ shortness of breath   ___ palpitations   ___ dizziness
   ___ sweatiness
   ___ other: ______________________________

6. If your patient has angina pain, describe the frequency, nature, location, radiation, precipitating factors, and severity of this pain: ______________________________

   ____

   ____

7. Does your patient have *marked limitation of physical activity*, as demonstrated by fatigue, palpitation, dyspnea, or angina discomfort on ordinary physical activity, even though your patient is comfortable at rest?   ___ Yes   ___ No

8. What is the role of stress in bringing on your patient's symptoms? ______________________________

   ____

9. To what degree can your patient tolerate work stress?

   ___ Incapable of even "low stress" jobs   ___ Capable of low stress jobs
   ___ Moderate stress is okay   ___ Capable of high stress work

a. Please explain the reasons for your conclusion: ______________________________

____

10. Do your patient's physical symptoms and limitations cause emotional difficulties such as depression or chronic anxiety? ___ Yes ___ No

Please explain: ____

11. Do emotional factors *contribute* to the severity of your patient's subjective symptoms and functional limitations? ___ Yes ___ No

12. How often during a typical workday is your patient's experience of cardiac symptoms (including psychological preoccupation with his / her cardiac condition, if any) severe enough to interfere with **attention and concentration** needed to perform even simple work tasks?

___ Never ___ Rarely ___ Occasionally ___ Frequently ___ Constantly

For this and other questions on this form, "rarely" means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.

13. Are your patient's impairments (physical impairments plus any emotional impairments) *reasonably consistent* with the symptoms and functional limitations described in this evaluation? ___ Yes ___ No

a. If no, please explain: ____

____

____

14. List of prescribed medications: ____

____

____

a. Describe any side effects of your patient's medication and identify any implications for working: ____

____

____

15. Have your patient's impairments lasted or can they be expected to last at least twelve months? ___ Yes ___ No

16. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in *a competitive work situation*:

a. How many city blocks can your patient walk without rest or severe pain? ______________

b. Please indicate how long your patient can sit and stand/walk *total in an 8 hour working day* (with normal breaks).

Sit	Stand / Walk	
___	___	less than 2 hours
___	___	about 2 hours
___	___	about 4 hours
___	___	at least 6 hours

c. Does your patient need a job that permits shifting positions *at will* from sitting, standing or walking? ___ Yes ___ No

d. Will your patient sometimes need to take unscheduled breaks during an 8 hour working day? ___ Yes ___ No

1. If yes, how *often* do you think this will happen? ______________________________

2. How *long* (on average) will your patient have to rest before returning to work? _______

____

3. On such a break, will your patient need to ___ lie down or ___ sit quietly?

e. With prolonged sitting, should your patient's leg(s) be elevated? ___ Yes ___ No

1. If yes, how *high* should the leg(s) be elevated? ______________________________

2. If your patient had a sedentary job, *what percentage of time* during an 8-hour working day should the leg(s) be elevated? ______________________________

____

f. How many pounds can your patient lift and carry in a competitive work situation?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.	___	___	___	___
10 lbs.	___	___	___	___
20 lbs.	___	___	___	___
50 lbs.	___	___	___	___

g. How often can your patient perform the following activities?

	Never	Rarely	Occasionally	Frequently
Twist	___	___	___	___
Stoop (bend)	___	___	___	___
Crouch / squat	___	___	___	___
Climb ladders	___	___	___	___
Climb stairs	___	___	___	___

h. State the degree to which your patient should avoid the following:

Environmental Conditions	**No Restrictions**	**Avoid Concentrated Exposure**	**Avoid Even Moderate Exposure**	**Avoid All Exposure**
Extreme cold	___	___	___	___
Extreme heat	___	___	___	___
High humidity	___	___	___	___
Wetness	___	___	___	___
Cigarette smoke	___	___	___	___
Perfumes	___	___	___	___
Soldering fluxes	___	___	___	___
Solvents / cleaners	___	___	___	___
Fumes, odors, gases	___	___	___	___
Dust	___	___	___	___
Chemicals	___	___	___	___
List other irritants:	___	___	___	___

17. Are your patient's impairments likely to produce "good days" and "bad days"?

___ Yes ___ No

a. If yes, will your patient likely to be absent from work 3 or more days per month:

___ Yes ___ No

18. What is the earliest date that the description of symptoms and limitations in this questionnaire applies? ______________________________

19. Please describe any other limitations (such as limitations using arms, hands, fingers, psychological limitations, limited vision, difficulty hearing, etc.) that would affect your patient's ability to work at a regular job on a sustained basis: ______________________________

____

____

____

Date: ______________________ Signature: ______________________

Printed/Typed Name: ______________________

Address: ______________________

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