SEIZURES
RESIDUAL FUNCTIONAL CAPACITY
QUESTIONNAIRE

To: _____

Re: _____ (Name of Patient)

_____ (Social Security No.)

Please answer the following questions concerning your patient's seizures. *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. Diagnoses: _____

_____

3. Does your patient have seizures? __ Yes __No

4. What type of seizures does your patient have? _____

5. Are the seizures __ generalized __ localized?

6. Is there loss of consciousness? __ Yes __ No

7 a. What is the average frequency of your patient's seizures?

_____ per week _____ per month

b. What are the dates of the last three seizures?

(1) _____ (2) _____ (3) _____

8. How long does a typical seizure last? _____

9. Does your patient always have a warning of an impending seizure? __ Yes __ No

If yes, how long is it between the warning and the onset of the seizure? _____minutes

Can your patient always take safety precautions when he/she feels a seizure coming on?

__ Yes __ No

10. Do seizures occur at a particular time of the day? __ Yes __ No

If yes, explain when seizures occur: _____

11. Are there precipitating factors such as stress, exertion? __ Yes __ No

If yes, explain: _____

12. What sort of action must others take during and immediately after your patient's seizure?

Check those that apply:

__ Put something soft under the head
__ Remove glasses
__ Loosen tight clothing
__ Clear the area of hard or sharp objects
__ After seizure, turn patient on side to allow saliva to drain from mouth
__ Other: _____

13. What are the postictal manifestations?

Check those that apply:

__ Confusion
__ Exhaustion
__ Irritability
__ Other: _____
__ Severe headache
__ Muscle strain
__ Paranoia

14. How long after a seizure do these postictal manifestations last? _____

15. Describe the degree to which having a seizure interferes with your patient's daily activities following a seizure:

_____

_____

16. Does your patient have a history of injury during a seizure? __ Yes __ No

17. Does your patient have a history of fecal or urinary incontinence during a seizure? __ Yes __ No

18 Type of medication and response: _____

_____

19. Is your patient compliant with taking medication? __ Yes __ No

If no, does it make a difference in the frequency of seizures? __ Yes __ No

20. Does your patient suffer any side effects of seizure medication?

Check those that apply:

___ Dizziness
___ Eye focusing problems
___ Lethargy
___ Other: _____
___ Double vision
___ Coordination disturbance
___ Lack of alertness

21. If your patient's blood levels of anticonvulsant medication have recently been at less than therapeutic levels, please explain why there has been difficulty controlling blood levels.

_____

_____

_____

22. Does your patient suffer from ethanol related seizures or ethanol/other drug abuse?
___ Yes ___ No

23. Are your patient's seizures likely to disrupt the work of co-workers?
___ Yes ___ No

24. Will your patient need more supervision at work than an unimpaired worker?
___ Yes ___ No

25. Can your patient work at heights? ___ Yes ___ No

26. Can your patient work with power machines that require an alert operator?
___ Yes ___ No

27. Can your patient operate a motor vehicle? ___ Yes ___ No

28. Can your patient take a bus alone? ___ Yes ___ No

29. Does your patient have any associated mental problems?

Check those that apply:

___ Depression
___ Irritability
___ Social isolation
___ Poor self-esteem
___ Short attention span
___ Memory problems
___ Behavior extremes
___ Other: _____

30. Will your patient sometimes need to take unscheduled breaks during an 8-hour working day? __ Yes __ No

If yes, 1) how *often* do you think this will happen? _____

2) how long (on average) will your patient have to rest before returning to work? _____

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

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

Please explain the reasons for your conclusion: _____

_____

32. Are your patient's impairments likely to produce "good days" and "bad days"? _____ _ Yes __No

If yes, please estimate, on the 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 one day per month
__ About two days per month
__ About three days per month
__ About four days per month
__ More than four days per month

33. Please describe any other limitations (such as limitations in the ability to sit, stand, walk, lift, bend, stoop, limitations in using arms, hands, fingers, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

_____

_____

34. What is the earliest date that the description of *symptoms and limitations* in this questionnaire applies? _____

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____

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