DIABETES MELLITUS
RESIDUAL FUNCTIONAL CAPACITYQUESTIONNAIRE

To: ______________________________

Re: ______________________________(Name of Patient)

______________________________(Social Security No.)

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. Diagnoses: ______________________________

3. Prognosis: ______________________________

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

__ fatigue	__ general malaise	__ extremity pain and numbness
__ difficulty walking	__ muscle weakness	__ loss of manual dexterity
__ episodic vision blurriness	__ retinopathy	__ diarrhea
__ bladder infections	__ kidney problems	__ frequency of urination
__ bed wetting	__ hot flashes	__ sweating
__ infections/fevers	__ psychological problem	__ difficulty thinking/ concentrating
__ excessive thirst	__ abdominal pain	
__ rapid heart beat/chest pain	__ vascular disease/ leg cramping	__ dizziness/loss of balance
__ swelling		__ headaches
__ chronic skin infections	__ insulin shock/coma	__ hyper/hypoglycemic attacks
__ sensitivity to light, heat or cold	__ nausea/vomiting	__ Other: ______________ ______________

5. Clinical findings: ______________________________

____

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

7. Is your patient a malingerer? __ Yes __ No

8. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? __ Yes __ No

9. Identify any psychological conditions affecting your patient's physical condition:

__ Depression __ Somatoform disorder __ Other: ______________
__ Anxiety __ Personality disorder ______________

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

If no, please explain: ______________________________

11. How often during a typical workday is your patient's experience of pain or other symptoms 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.

12. 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

13. 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 circle the hours and/or minutes that your patient can sit ***at one time,*** e.g., before needing to get up, etc.

Sit: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

c. Please circle the hours and/or minutes that your patient can stand ***at one time***, e.g., before needing to sit down, walk around, etc.

Stand: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

d. 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

e. Does your patient need to include periods of walking around during an 8-hour working day? __ Yes __ No

1. If yes, approximately how *often* must your patient walk?

1 5 10 15 20 30 45 60 90
Minutes

2. How *long* must your patient walk each time?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Minutes

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

g. 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? ____________

3) on such a break will your patient need to __ lie down or __ sit quietly?

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

If yes, 1) 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? ____________

i. While engaging in occasional standing/walking, must your patient use a cane or other assistive device? __ Yes __ No

j. 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.	__	__	__	__

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

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

l. Does your patient have significant limitations with reaching, handling or fingering?
__ Yes __ No

If yes, please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

	HANDS: **Grasp, Turn** **Twist Objects**	**FINGERS:** **Fine** **Manipulations**	**ARMS:** **Reaching** **(incl. Overhead)**
Right:	___%	___%	___%
Left:	___%	___%	___%

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

ENVIRONMENTAL RESTRICTIONS	**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:				
______________	__	__	__	__

n. Are your patient's impairments likely to produce "good days" and "bad days"?
__ Yes __ No

If yes, will your patient likely to be absent from work 3 or more days per month:
__ Yes __ No

14. Please attach an additional page to describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, etc.) that would affect your patient's ability to work at a regular job on a sustained basis.

15. 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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