

**CARDIAC
RESIDUAL FUNCTIONAL CAPACITY
QUESTIONNAIRE**

To: _____

Re: _____ (Name of Patient)

_____ (Social Security No.)

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

1. Nature, frequency and length of contact: _____

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

3. Identify the clinical findings, laboratory and test results which show your patient's medical impairments:

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

- | | | | |
|-----|-------------------------|-----|--------------|
| ___ | chest pain | ___ | edema |
| ___ | anginal equivalent pain | ___ | nausea |
| ___ | shortness of breath | ___ | palpitations |
| ___ | fatigue | ___ | dizziness |
| ___ | weakness | ___ | sweatiness |

Other: _____

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

6. Is your patient a malingerer?

Yes No

7. Does your patient have *marked limitation of physical activity*, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though your patient is comfortable at rest?

Yes No

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

b. 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

c. Please explain the reasons for your conclusions: _____

9. Do your patient's physical symptoms and limitations cause emotional difficulties such as depression or chronic anxiety?

Yes No

Please explain:

10. Do emotional factors contribute to the severity of your patient's subjective symptoms and functional limitations?

Yes No

11. How often 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?

Never Seldom Often Frequently Constantly

12. 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

If no, please explain: _____

13. a. List of prescribed medications:

Name of medication and dosage

Daily amount taken

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

14. Prognosis:

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 which 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

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?

e. 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? _____%

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

	Never	Occasionally	Frequently
less than 10 lbs.	___	___	___
10 lbs.	___	___	___
20 lbs.	___	___	___
50 lbs.	___	___	___

In an average 8 hour working day, "occasionally" means less than 1/3 of the working day; "frequently" means between 1/3 to 2/3 of the working day.

g. Please state the percentage of time during an 8 hour working day that your patient can bend and twist at the waist.

Bend _____% Twist _____%

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

ENVIRONMENTAL RESTRICTIONS:	NO RESTRICTION	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Extreme cold				
Extreme heat				
High humidity				
Fumes, odors, dusts, gases				
Perfumes				
Cigarette smoke				
Soldering fluxes				
Solvents/cleaners				
Chemicals				
List other irritants or allergens:				

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

Yes No

If yes, please estimate, on the average, how often your patient is likely to be absent from work as a result of the impairments or treatment:

- | | |
|----------------------------|-----------------------------------|
| ___ Never | ___ About twice a month |
| ___ Less than once a month | ___ About three times a month |
| ___ About once a month | ___ More than three times a month |

17. Identify any additional tests or procedures you would advise to fully assess your patient's impairments, symptoms and limitations:

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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