To: Social Security Administration 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 that have not been provided previously to the Social Security Administration.***

1. Frequency and length of contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Prognosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. The patient’s symptoms are as follows:

\_\_\_ chronic diarrhea \_\_\_ malaise

\_\_\_ bloody diarrhea \_\_\_ fatigue

\_\_\_ anxiety \_\_\_ mucus in stool

\_\_\_ kidney problems \_\_\_ loss of appetite

\_\_\_ fever \_\_\_ ineffective straining at stool  
 (rectal tenesmus)

\_\_\_ chronic urination

\_\_\_ fatigue \_\_\_ eye problems

\_\_\_ weight loss \_\_\_ pain

\_\_\_ loss of appetite \_\_\_ dizziness

\_\_\_ bowel obstruction \_\_\_ fatigue

\_\_\_ vomiting \_\_\_ weight loss

\_\_\_ abdominal distention \_\_\_ abdominal pain and cramping

\_\_\_ anal fissures \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ peripheral arthritis \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Identify the clinical findings and objective signs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. a. If your patient has pain or episodic symptom otology, including the need to unexpectedly use or be near toilet facilities for the purpose of defecation, urination or draining and/or cleansing anatomy bag and characterize the nature, location, frequency, precipitating factors, and severity of your patient's pain and/or need to use facilities:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. If aspects of your patient's impairment are episodic, describe the nature, precipitating factors, inclusive of taste, smell food, drink severity, frequency and duration of the episodic and/or aspects of symptom otology: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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7. Describe the treatment and response including any side effects of medication that may have implications for working, e.g., drowsiness, dizziness, nausea, etc.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have your patient’s impairments lasted or can they be expected to last 12 months? \_\_\_Yes \_\_\_No

9. Do emotional factors contribute to the severity of your patient’s symptoms and functional limitations? \_\_\_Yes \_\_\_No

10. Identify any psychological conditions affecting your patient’s physical condition:

\_\_\_Depression \_\_\_Anxiety

\_\_\_Personality Disorder \_\_\_Somatoform disorder

\_\_\_Psychological factors affecting physical condition \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Are your patient’s impairments (physical impairments plus any emotional impairments) *reasonably consistent* with the symptoms and functional limitations described in the evaluation?

\_\_\_Yes \_\_\_No

!2. 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, as best you can, please estimate your patient’s functional limitations if your patient were placed in a *hypothetical 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 1 2 More than 2

**Minutes 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 1 2 More than 2

**Minutes 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**

1. 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 restroom 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 be away from the work

station for an average unscheduled restroom break? \_\_\_\_\_\_\_\_\_\_

3) How much advance notice does your patient have of the need for restroom break? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

h. Will your patient also sometimes need to lie down or rest at unpredictable intervals during an 8-hour working day? \_\_\_Yes \_\_\_No

**If yes,** 1) How often do you think this will happen? \_\_\_\_ per hour/day

2) How long (on average) will your patient

have to rest before returning to work? mins/hrs

1. 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? \_\_\_\_\_%

***Regarding the questions contained within 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.***

14. a. Aside from scheduled routine breaks of 15minutes in the mid morning, and mid afternoon and ½ hour lunch break, how often during a typical workday is your patient’s experience of pain including intestinal pain, or urinary tract discomfort and urge to use the bathroom or other symptoms severe enough to interfere with **attention and concentration** needed to perform even simple tasks?

**\_\_\_Never \_\_\_Rarely \_\_\_Occasionally \_\_\_Frequently \_\_\_Constantly**

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

**Never Rarely Occasionally Frequently**

Less than 10 lbs. \_\_\_ \_\_\_ \_\_\_ \_\_\_

10 lbs. \_\_\_ \_\_\_ \_\_\_ \_\_\_

20 lbs. \_\_\_ \_\_\_ \_\_\_ \_\_\_

50 lbs. \_\_\_ \_\_\_ \_\_\_ \_\_\_

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

**Never Rarely Occasionally Frequently**

Twist \_\_\_ \_\_\_ \_\_\_ \_\_\_

Stoop (bend) \_\_\_ \_\_\_ \_\_\_ \_\_\_

Crouch \_\_\_ \_\_\_ \_\_\_ \_\_\_

Climb ladders \_\_\_ \_\_\_ \_\_\_ \_\_\_

Climb stairs \_\_\_ \_\_\_ \_\_\_ \_\_\_

15. 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 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

16. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, distraction due to intestinal or urinary tract pain, discomfort or urge to use the bathroom facilities that would affect your patient’s ability to work at a regular job on a sustained basis without significant interruption:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. In your opinion based on the Claimant’s medical history and/or clinical presentation what is the **earliest date** that the description of symptoms and limitations in this questionnaire applies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Physician’s Signature Date form completed*

**Return form to:**

***Printed/Typed Name****:*  **Mike Murburg, PA**

*Address:* **15501 N. Florida Ave**

**Tampa, FL 33613**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: 813-264-5363**

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