Fibromyalgia Residual Functional Capacity Questionnaire

Name: _________________________ SSN:_________________

Please answer the following questions concerning your BEST ESTIMATE of your patient's impairments. Attach all relevant treatment notes, radiologist reports, laboratory and test results.

1. Does your patient meet the American Rheumatological criteria for fibromyalgia?  
   Yes  
   No

2. List any other diagnosed impairments?______________________________________

3. Prognosis:__________________________________________________________

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

5. Identify you patient's symptoms:
   Multiple Tender Points       Numbness and Tingling       Non restorative sleep
   Sicca symptoms             Chronic fatigue                Raynoud's phenomenon
   Dysmenorrhea                Breathlessness                Muscle weakness
   Anxiety                     Subjective swelling            Panic attacks
   Irritable bowel syndrome   Depression                     Frequent, severe headaches
   Mitral valve prolapse      Female Urethral Syndrome       Hypothyroidism
   Carpal Tunnel Syndrome     Vestibular dysfunction
   Other___________________

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

7. If your patient has pain: Identify the location of pain including where appropriate, an indication of right and/or left side affected:  
   Right   Left
   Shoulders
   Arms
   Hands/fingers
   Hips
   Legs
   Knees/ankles/feet
   Lumbosacral spine       Cervical spine
   Thoracic spine
   Chest

8. Identify any factors that precipitate pain:  
   Changing weather          Fatigue               Movement/Overuse
   Cold                      Stress                Hormonal changes
   Static position

9. Are your patient's impairments reasonably consistent with the symptoms and functional limitations described?  
   Yes  
   No  
   If No, explain:_______________________________________________

10. How often is pain severe enough to interfere with attention and concentration?  
    Never   Seldom   Often   Frequently
    Constantly

11. To what degree is the patient limited in the ability to deal with work stress?  
    No limitation   Slight   Moderate   Marked   Severe limitation
12. Are your patient's impairments likely to produce "good days" and "bad days"?  Yes  No

13. Is your patient a malingering?  Yes  No

14. As a result of your patient's impairments, estimate your patient's functional limitations if they were placed in a competitive work situation:
   a. Circle hours and/or minutes that he/she can continuously sit and stand at one time:
      
      | Minutes | Hours |
      |---------|-------|
      | 0 5 10 15 20 30 45 | 1 2 more than 2 |

      1. Sit: 0 5 10 15 20 30 45 1 2 more than 2
      2. Stand: 0 5 10 15 20 30 45 1 2 more than 2

   b. Indicate how long he/she can sit and stand/walk total in an 8 hour work day:
      
      | Sit |
      |------|
      | less than 2 hours |
      | about 2 hours |
      | about 4 hours |
      | at least 6 hours |

      | Stand/walk |
      |------------|
      | less than 2 hours |
      | about 2 hours |
      | about 4 hours |
      | at least 6 hours |

15. How many pounds can he/she lift and carry in a work situation?
   
<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
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<tbody>
<tr>
<td>Less than 10 lbs.</td>
<td></td>
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<tr>
<td>10 lbs.</td>
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<tr>
<td>20 lbs.</td>
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<tr>
<td>50 lbs.</td>
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16. Does your patient have significant limitations in doing repetitive reaching, handling or fingering?  Yes  No

Date: _______________________  Signature:____________________________

Printed/Typed Name:____________________________