

SARCOIDOSIS FUNCTIONAL CAPACITY QUESTIONNAIRE

To: _____

_____ (Name of Patient)
_____ (Social Security Number)
_____ (Date of Birth)

1. Please answer the following questions concerning your patient's impairments.

- a. Date of first treatment: _____
b. Date of most recent exam: _____
c. Frequency of treatment: _____

2. Prognosis:

3. Identify the positive clinical findings and diagnostic test results that demonstrate and/or support your diagnosis the diagnosis of sarcoidosis.

4. Was a biopsy performed?

_____ No _____ Yes

5. Which organs does the sarcoidosis affect?

___ Lungs ___ Heart ___ Liver ___ Spleen ___ Eyes ___ Kidneys

___ Central Nervous System ___ Skin ___ Lymph Nodes

6. Has there been any evidence of progression? If yes please explain: _____

7. Please circle the current stage of your patient's sarcoidosis?

I II III IV

8. Which of the following sarcoidosis associated symptoms are present?

_____ Persistent cough _____ Joint arthritis _____ Red/watery
_____ eyes
_____ Fatigue _____ Weight loss _____ Skin Sores

_____ Other (Please describe) _____

9 Does the patient's medications cause side effects which would interfere with concentration, persistence and pace?

Yes

No

10. As a result of your patient's impairments, estimate your patient's residual functional capacity if your patient were placed in a normal COMPETITIVE, FIVE DAY A WEEK WORK ENVIRONMENT ON A SUSTAINED BASIS.

In an eight-hour day, my patient can only (circle full capacity for each activity)

Sit 0-1 2 3 4 5 6 7 8 (Hours)

Stand/Walk 0-1 2 3 4 5 6 7 8 (Hours)

11. My patient can:

Lift/Carry

Never

Occasionally

Frequently

0-5 lbs.

5-10 lbs.

10-20 lbs.

20-50 lbs.

Over 50 lbs.

12. **GRASPING/TURNING OBJECTS:**

Right: _____ Never _____ Occasionally¹ _____ Frequently²

Left: _____ Never _____ Occasionally _____ Frequently

13. **HANDLING/FINGERING:**

Right: _____ Never _____ Occasionally _____ Frequently

Left: _____ Never _____ Occasionally _____ Frequently

14. **REACHING:**

Right: _____ Never _____ Occasionally _____ Frequently

Left: _____ Never _____ Occasionally _____ Frequently

15. Does the patient require an assistive device for standing or walking? _____ Yes _____ No

If yes: _____ Cane _____ Walker _____ Other

¹ 1%-33% of an eight hour working day.

² 34%-66% of an eight hour working day.

16. How often is your patient's experience of pain, fatigue or other symptoms severe enough to interfere with attention and concentration?

Never Seldom Periodically Frequently Constantly

17. Identify factors that precipitate pain:

Changing weather Fatigue Movement/Overuse Cold
 Stress Hormonal Changes Static Position

18. Are your patient's impairments ongoing, creating an expectation on your part that they will last at least twelve months? Yes No

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

Incapable of even "low stress"
 Capable of low stress
 Capable of moderate stress
 Capable of high stress

20. Will your patient sometimes need to take unscheduled breaks to rest at unpredictable intervals during an 8-hour day? Yes No

If yes: How often do you think this will happen? _____

21. How long (on average) will your patient have to rest before returning to work? _____

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

More than three times a month
 About once a month
 About two to three times a month
 Less than once a month

23. Are there any other limitations that would affect your patient's ability to work at a regular job on a sustained basis (please check all that are applicable)?

psychological limitations avoid noise avoid fumes
 avoid gases limited vision avoid temperature extremes
 avoid humidity avoid heights avoid dust
 no pulling no pushing no kneeling
 no bending no stooping

24. In your best medical opinion, what is the earliest date the description of symptoms and limitations in this questionnaire applies?

25. Is drug or alcohol use a material factor in your patient's disability? _____

Signature

Date

Specialty

Print/Type Name

Address

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