Cardiac Questionnaire Doctor-Adult

[Standard Header]
Patient Name: [ClmFtNm] [ClmLtNm]

[Barcode]

PLEASE COMPLETE AND RETURN BY [CalcReturnDate]

CARDIAC QUESTIONNAIRE

1. Diagnosis: _____ Date of diagnosis: _____

2. Date and findings of most recent exam: _____
   _____

3. Would undergoing exercise testing pose significant risk for your patient? ☐ Yes ☐ No

4. If the patient has chest pain, is it related to a cardiac condition? ☐ Yes ☐ No If no, what non-cardiac condition is causing chest pain? _____

5. Has the patient experienced cyanosis at rest? ☐ Yes ☐ No On exertion? ☐ Yes ☐ No

6. Describe the patient's cardiac signs and symptoms (for example, dyspnea, fatigue, palpitations, chest discomfort, edema, varicosities, stasis dermatitis, ulcerations, claudication). _____
   _____
   _____

7. Describe the location, duration, and frequency of the patient's symptoms. _____
   _____

8. Describe any precipitating factors (for example, physical activity, eating, cold air). _____
   _____

9. What relieves the patient's symptoms (for example, rest, position, medication)? _____
   _____

10. Are the symptoms acute or chronic? _____

11. Current New York Heart Association class rating: _____ Based on this rating describe the patient's physical limitations (for example, difficulty with household tasks, walking, stairs, lifting). _____
    _____

[Standard Footer]

12. Describe any evidence of neurological complications (for example, ataxia, paralysis, aphasia). _____
_____

13. Is there evidence of end-organ damage as a result of hypertension (for example, kidney failure, retinopathy)? ☐ Yes ☐ No If yes, describe. _____
_____

14. Treatment:

MEDICATION	DOSAGE AND FREQUENCY

PAST TREATMENT OR RECOMMENDATION(S) (for example, angioplasty, CABG, pacemaker)	DATE PERFORMED OR SCHEDULED

15. Have the symptoms persisted despite treatment? _____
_____

16. Describe any restrictions to work-related activities, if not previously provided (for example, walking, lifting, carrying).
_____
_____
_____
_____

NOTE: Please submit copies of tracings, testing, and laboratory results, if you have not provided them previously.

_____ _____ _____
Physician's Signature Date Phone Number

_____ _____
Printed Name Title

Paperwork Reduction Act Statement – This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to provide this information unless we display a

[Standard Footer]

valid Office of Management and Budget (OMB) control number. The OMB control number for this collection is 0960-0555. We estimate that it will take between 5-30 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

Cardiac Questionnaire Clmt-Adult

[Standard Header]
Claimant Name: [ClmFtNm] [ClmLtNm]

[Barcode]

PLEASE COMPLETE AND RETURN BY [CalcReturnDate]

CARDIAC QUESTIONNAIRE

If you need more space, please attach additional page(s).

1. Do you have any chest discomfort? ☐ Yes ☐ No
    a. How often does it occur? _____
    _____
    b. What brings on your chest discomfort? _____
    _____
    c. What does it feel like? _____
    _____
    d. How long do episodes last? _____
    e. What relieves it? _____
    _____
    f. Does it radiate? If so, where? _____
    g. Does it occur at rest? _____
    h. Does it awaken you from sleep? _____
2. Do you have shortness of breath? ☐ Yes ☐ No
    a. When does it occur? _____
    b. What brings it on? _____
    c. What relieves it? _____
    d. How far can you walk without stopping to rest? _____
    e. How many flights of stairs can you climb without stopping to rest? _____

[Standard Footer]

3. Do you have additional symptoms (for example, fatigue, weakness, lightheadedness).
☐ Yes ☐ No If yes, describe.

_____
_____
_____

4. List current cardiac medication(s).

MEDICATION	DATE STARTED	IF PRESCRIBED, NAME OF DOCTOR	DOSAGE AND FREQUENCY	SIDE EFFECT(S)

5. Describe any activities you have stopped due to shortness of breath or chest discomfort.

_____
_____
_____

6. If you have seen any medical professionals for your cardiac condition since you filed your claim, complete the chart below.

NAME	ADDRESS AND PHONE NUMBER	DATE OF LAST VISIT	DATE OF NEXT VISIT

_____ _____ _____
Name of person completing this form (Please print) Date Phone

Address	City	State	ZIP

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Cardiac Questionnaire Doctor-Child

[Standard Header]
Child Name: [ClmFtNm] [ClmLtNm]

[Barcode]

PLEASE COMPLETE AND RETURN BY [CalcReturnDate]

CHILD CARDIAC QUESTIONNAIRE

1. Diagnosis: _____ Date of diagnosis: _____

2. Date and findings of most recent exam: _____
   _____

3. Current height and percentile: _____ Current weight and percentile: _____

4. For children under two: Birth Length: _____ Birth Weight: _____

5. Has the child had involuntary weight loss or failure to gain weight that has persisted for two months or longer? ☐ Yes ☐ No If yes, provide copies of records to include longitudinal history of height, weight, and growth percentiles. _____
   _____
   _____

6. For children age six or older, would undergoing exercise testing pose significant risk for the child? ☐ Yes ☐ No

7. If the child has chest pain, is it related to a cardiac condition? ☐ Yes ☐ No If no, what non-cardiac condition is causing chest pain? _____

8. Describe the child's cardiac signs and symptoms (for example, syncope, cyanosis, edema, dyspnea, weakness, palpitations, weight loss or gain). _____
   _____
   _____

9. Describe the location, duration, and frequency of the child's symptoms. _____
   _____

10. Describe any precipitating factors (for example, physical activity, eating, cold air). _____
    _____

11. What relieves the child's symptoms (for example, rest, position, medication)? _____
    _____

[Standard footer]

12. Are the symptoms acute or chronic? _____

13. Describe any evidence of neurological complications (for example, weakness, spasticity, incoordination, ataxia, tremor) resulting from the child's cardiac condition(s).
_____
_____

14. Is there evidence of end-organ damage as a result of hypertension (for example, kidney failure, retinopathy)? ☐ Yes ☐ No If yes, describe._____
_____

15. Describe any cognitive deficits resulting from the child's cardiovascular disease or treatments for the cardiac condition(s). _____
_____
_____

16. Treatment:

MEDICATION	DOSAGE AND FREQUENCY

PAST TREATMENT OR RECOMMENDATION(S) (for example, pacemaker, defibrillator, corrective surgery)	DATE PERFORMED OR SCHEDULED

17. Have the symptoms persisted despite treatment? _____
_____

18. Describe any restrictions to age appropriate activities, if not previously provided (for example, acquiring and using information, attending and completing tasks, interacting and relating with others, moving about and manipulating objects, self-care).
_____
_____
_____
_____

NOTE: Please submit copies of tracings, testing, and laboratory results, if you have not provided them previously.

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Physician's Signature	Date	Phone Number
Printed Name		Title

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Epilepsy Questionnaire Doctor-Adult

[Standard Header]
Patient Name: [ClmFtNm] [ClmLtNm]

[Barcode]

PLEASE COMPLETE AND RETURN BY [CalcReturnDate]

EPILEPSY QUESTIONNAIRE

1. Date of most recent examination: _____

2. Diagnoses: _____

3. Indicate the type of seizures: ☐ Convulsive
   ☐ Non-Convulsive

4. Dates of last two seizures: _____ _____

5. Describe typical seizures (include all associated phenomena, such as aura, loss of consciousness, tonic or clonic movement, incontinence, alteration of awareness, unconventional behavior, duration, etc.). _____
   _____
   _____

6. Describe postictal manifestations and duration. _____
   _____
   _____

7. If convulsive, when do episodes occur?
   ☐ Day (with loss of consciousness and convulsive seizures)
   ☐ Night

8. Seizures witnessed by physician or staff member? ☐ Yes ☐ No If yes, describe.
   _____
   _____

9. Treatment:

MEDICATION	DOSAGE AND FREQUENCY	SIDE EFFECT(S)

[Standard footer]

Other treatment: _____
_____
_____

10. Are seizures controlled with medication? ☐ Yes ☐ No If no, explain. _____
_____
_____

11. Frequency of seizures after prescribed treatment: _____
_____
_____

12. Serum levels:

DRUG	DATE	RESULT

13. If serum drug levels are therapeutically inadequate, explain further. _____
_____
_____

14. Describe any functional limitations resulting from the patient's condition (for example, driving, physical activity, hazardous conditions). _____
_____
_____

15. Describe any restrictions to work-related activities, if not previously provided (for example, walking, lifting, carrying).
_____
_____
_____
_____

NOTE: Please submit copies of any testing and laboratory results, if you have not provided them previously.

_____ _____ _____
Physician's Signature Date Phone Number

_____ _____
Printed Name Title

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Seizure Questionnaire Clmt-Adult

[Standard Header]
Claimant Name: [ClmFtNm] [ClmLtNm]

[Barcode]

PLEASE COMPLETE AND RETURN BY [CalcReturnDate]

SEIZURE QUESTIONNAIRE

If you need more space, please attach additional page(s).

1. Do you have seizures? ☐ Yes ☐ No

    a. When was your first seizure? _____

    b. When did you have your last seizure? _____

    c. Do your seizures usually occur during the day, during the night, or both? Please explain. _____
    _____

    d. How long do the seizure(s) last? _____

    e. How often do seizures occur? _____

    f. List the approximate date(s) of seizure(s) in the last 12 months. _____
    _____
    _____

    g. Describe what happens before, during, and after you have a seizure and how long until you can resume normal activity. _____
    _____
    _____
    _____

2. Describe any event(s) that cause your seizure(s). _____
    _____
    _____
    _____

3. List current seizure medication(s).

MEDICATION	DATE STARTED	IF PRESCRIBED, NAME OF	DOSAGE AND	SIDE EFFECT(S)

[Standard Footer]

		DOCTOR	FREQUENCY	

4. Have you visited an emergency room for seizures? If so, when and where? _____
   _____

5. If you have seen any medical professionals for your seizures since you filed your claim, complete the chart below.

NAME	ADDRESS AND PHONE NUMBER	DATE OF LAST VISIT	DATE OF NEXT VISIT

6. Provide the name, address, and phone number of any medical professionals and other individuals (including a non-family member) who have witnessed your seizure(s).

NAME	ADDRESS	PHONE NUMBER

_____ _____ _____
Name of person completing this form (Please print) Date Phone

_____ _____ _____ _____
Address City State ZIP

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Seizure Questionnaire Witness

[Standard Header]
Individual's Name: [ClmFtNm] [ClmLtNm]

[Barcode]

PLEASE COMPLETE AND RETURN BY [CalcReturnDate]

SEIZURE WITNESS QUESTIONNAIRE

If you need more space, please attach additional page(s).

1. What is your relationship to this individual? _____
2. How long have you known this individual? _____
3. How often do you see this individual? _____
4. How many times have you seen this individual have a seizure? _____
5. What is the approximate date of the last seizure you saw? _____
6. Were there any changes in the individual's behavior just before a seizure? ☐ Yes ☐ No
   If yes, explain. _____
   _____
   _____
7. Describe what happened to the individual during a seizure (for example, did the individual lose consciousness, fall down, stare into space, lose bowel or bladder control, bite tongue, have repeated body movements, suffer an injury)? _____
   _____
   _____
   _____
8. Describe any problems the individual had after a seizure (for example, confusion, tiredness, difficulty talking or walking) and how long the problems lasted. _____
   _____
   _____
9. Did the individual remember having a seizure? ☐ Yes ☐ No
10. How long does a seizure typically last? _____
11. In addition to seizures you have witnessed, do you know about any other seizures?
    ☐ Yes ☐ No If yes, explain. _____

[Standard Footer]

_____

_____

_____

Name of person completing this form (Please print)	Date	Phone	
Address	City	State	ZIP

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SSA will insert the following revised PRA Statement into the form at its next scheduled reprinting:

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. The OMB control number for this collection is 0960-0555. We estimate that it will take between 5 to 30 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

PRIVACY ACT STATEMENT
Collection and Use of Information by the Social Security Administration

The Privacy Act of 1974 (5 U.S.C. § 552a) requires us to provide certain facts to each person from whom we request and collect information in order to administer our programs. These facts include:

- the statutory authority for the request;
- why we need the information;
- whether it is voluntary or mandatory for you to give us the information and the effects, if any, of not giving us the information; and
- the uses we may make of the information you give us.

The following sections explain our collection, use, and disclosure of the information you give us. If you have any questions about your rights and responsibilities under the Privacy Act, you may contact any local Social Security office.

Our authority to collect information

Our specific authority to collect information is found in sections 205(a), 702, 1631(e)(1)(A) and (B), 1631(f), 1872, and 1875 of the Social Security Act (the Act), as amended. Additional authority is in part B of the Federal Coal Mine Health and Safety Act of 1969.

Why we need the information

We collect information from you in order to administer our programs. Specifically, the information we request enables us to:

- assign Social Security numbers;
- establish and maintain earnings records;
- determine entitlement of applicants and their families to insurance coverage and or benefit payments;
- issue payments in the right amount for the right months to people entitled to them; and
- conduct program-oriented research in areas of income distribution and maintenance.

Is providing information voluntary or mandatory?

It is not mandatory for you to give us the information we request ***except*** in certain instances explained below. It is usually to your advantage to comply with our request for information. Failure to do so, however, could prevent an accurate and timely decision on a claim you file or result in the loss of some benefit or service.

Our use(s) of the information you give us

We use the information you give us to administer our programs. Sometimes we must disclose the information to another agency or person without your written consent. We make these disclosures for the following reasons:

- to enable a third party or agency to assist us in establishing your right to benefits or coverage;
- to comply with Federal laws;
- to make eligibility determinations in similar Federal, State, and local health and income maintenance programs;
- to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of our programs.

We may also use the information you give us when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use the information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses of the information you give us is available in our Privacy Act Systems of Records Notices. For example, the application for benefits and supporting documentation of the factors of entitlement and continuing eligibility is contained in our Claims Folder System (60-0089); medical information, doctors' reports, and State disability determinations related to a disability claim is contained in our National Disability Determination Services File System (60-0044). Additional information regarding this form, routine uses of information, and other Social Security programs is available from our Internet website at www.socialsecurity.gov or at your local Social Security office.