

Cardiac Questionnaire Doctor-Adult

[Standard Header]

Patient Name: [C1mFtNm] [C1mLtNm]

[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]



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.**

**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? \_\_\_\_\_

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

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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.

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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

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Address

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City

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State

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ZIP

**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 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.***

**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)? \_\_\_\_\_  
\_\_\_\_\_

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

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Date

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Phone Number

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Printed Name

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Title

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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: [CImFtNm] [CImLtNm]

[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)
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		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: [C1mFtNm] [C1mLtNm]

[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]



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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:***

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# 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](http://www.socialsecurity.gov) or at your local Social Security office.