

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]

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

~~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.

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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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.

Physician's Signature

Date

Phone Number

Printed Name

Title

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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)

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]

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

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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 or at your local Social Security office.~~

SSA will insert the following revised Privacy Act and PRA Statements into the form as soon as possible:

**Privacy Act Statement
Collection and Use of Personal Information**

Sections 205(a), 223(d) and 1631(d) and (e) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on any claim filed.

We will use the information to make a determination regarding your ability to perform work-related activities. We may also share your information for the following purposes, called routine uses:

1. To private medical and vocational consultants for use in making preparation for, or evaluating the results of, consultative medical examination or vocational assessments which they were engaged to perform by SSA or a State agency acting in accord with sections 221 or 1633 of the Act; and
2. To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs. We will disclose information under this routine use only in situations in which SSA may enter into a contractual or similar agreement with a third party to assist in accomplishing an agency function relating to this system of records.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0044, entitled National Disability Determination Services File System and 60-0089, entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

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