Cardiac Questionnaire Clmt-Adult

Form Approved
OMB No. 0960-0555

[Standard Header]
Claimant Name: [Clmt Full Name]

{barcode}

PLEASE COMPLETE AND RETURN BY {current + 14 days}

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, DOSAGE, AND FREQUENCY	DATE STARTED	IF PRESCRIBED, NAME OF HEALTH CARE PROFESSIONAL	SIDE EFFECT(S)

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

_____

_____

_____

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

NAME OF HEALTH CARE PROFESSIONAL	ADDRESS AND PHONE NUMBER	DATE OF LAST VISIT AND NEXT SCHEDULED APPOINTMENT (IF ANY)

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

Address _____ City _____ State _____ ZIP _____

Form Approved
OMB No. 0960-0555

[Standard Header]
Claimant Name: {clmt_full_name}

{barcode}

PLEASE COMPLETE AND RETURN BY {clmt_form_return_date}

SEIZURE QUESTIONNAIRE

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

1) Do you have seizures? ☐ Yes ☐ No

If yes:

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 event(s) that cause your seizure(s).

_____

_____

_____

3) List current seizure medication(s).

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

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

_____

_____

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

NAME OF HEALTH CARE PROFESSIONAL	ADDRESS AND PHONE NUMBER	DATE OF LAST VISIT AND NEXT SCHEDULED APPOINTMENT (IF ANY)

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

WITNESS NAME	ADDRESS AND PHONE NUMBER	PHONE NUMBER

_____ _____ _____

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

_____ _____ _____ _____

Address City State ZIP

[Paperwork Reduction Act]

Form Approved
OMB No. 0960-0555

[Standard Header]
Individual Name: {clmt_full_name}

{barcode}

PLEASE COMPLETE AND RETURN BY {third_party_form_return_date}

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.

_____

_____

_____

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

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 Notices (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.

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. We estimate that it will take about 20 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*.