

FIBROMYALGIA SYNDROME MEDICAL ASSESSMENT FORM

TO: Dr. _____

RE: _____

SSN: _____

Please answer the following questions concerning your patient's fibromyalgia and other impairments.

1. Date began treatment: _____ Frequency of Tx: _____

2. Does your patient meet the 1990 diagnostic criteria for **fibromyalgia** syndrome identified by the American College of Rheumatology including the presence of multiple tender points?

___ Yes ___ No

Does your patient exhibit **chronic fatigue syndrome**? ___ Yes ___ No

Other diagnoses: _____

3. Prognosis: _____

4. Identify all of your patient's **symptoms**:

- | | |
|---|---------------------------------------|
| ___ chronic pain | ___ numbness and tingling/parasthesia |
| ___ non-restorative sleep | ___ sicca symptoms |
| ___ muscle weakness | ___ chronic fatigue |
| ___ breathlessness | ___ Raynaud's phenomenon |
| ___ morning stiffness | ___ dysmenorrhea |
| ___ subjective swelling | ___ anxiety/panic attacks |
| ___ multiple chemical sensitivities | ___ irritable bowel syndrome |
| ___ frequent, severe headaches | ___ depression |
| ___ female urethral syndrome | ___ mitral valve prolapsed |
| ___ premenstrual syndrome (PMS) | ___ hypothyroidism |
| ___ vestibular dysfunction | ___ carpal tunnel syndrome |
| ___ temporomandibular joint dysfunction (TMJ) | |
| ___ other: _____ | |

A. If your patient exhibits chronic **pain/parasthesia**, characterize the **severity** of the pain/parasthesia: ___ mild ___ moderate ___ severe

B. Identify the location and frequency of **pain/parasthesia** by shading the relevant body portions and labeling as constant (C), frequent (F), or intermittent (I):

- C. Identify any positive objective signs of your patient's impairment(s):
- | | | |
|---|---|--|
| <input type="checkbox"/> SLR left at <input type="checkbox"/> % | <input type="checkbox"/> tenderness | <input type="checkbox"/> weight change |
| <input type="checkbox"/> right at <input type="checkbox"/> % | <input type="checkbox"/> crepitus | <input type="checkbox"/> joint warmth |
| <input type="checkbox"/> sensory changes | <input type="checkbox"/> joint changing | <input type="checkbox"/> reflex changes |
| <input type="checkbox"/> spasm | <input type="checkbox"/> impaired sleep | <input type="checkbox"/> atrophy |
| <input type="checkbox"/> muscle weakness | <input type="checkbox"/> impaired appetite | <input type="checkbox"/> motor loss |
| <input type="checkbox"/> abnormal gait | <input type="checkbox"/> limitation of motion | <input type="checkbox"/> joint instability |
| <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> joint deformity | <input type="checkbox"/> reduced grip strength |
| <input type="checkbox"/> other: _____ | | |

5. Identify any other positive clinical findings and test results (e.g., myelogram, MRI, CT scans, EMG/NCS):
- _____

For this and other questions on this form, "rarely" means 1% to 5% of an eight-hour working day; "occasionally" means 6% to 33% of an eight-hour working day; "frequently" means 34% to 66% of an eight-hour working day.

6. If your patient experiences symptoms which interfere with the **attention and concentration** needed to perform even simple tasks, during a typical workday, please estimate the **frequency** of interference:
- rarely occasionally at least frequently
7. If your patient was placed in a competitive job, identify those aspects of **workplace stress** that you patient would be **unable to perform** or be exposed to:
- public contact
- routine, repetitive tasks at consistent pace
- detailed or complicated tasks
- strict deadlines
- close interaction with coworkers/supervisors
- fast paced tasks (e.g., production line)
- exposure to work hazards (e.g., heights or moving machinery)
- other: _____

8. Identify any **side effects** of any medications which may have implications for working:

drowsiness/sedation other: _____

9. Have your patient's impairments lasted or can they be expected to last at least twelve months?

E. With prolonged sitting, should your patient's legs be **elevated**? _____ Yes _____ No

If yes, 1) How *high* should the leg(s) be elevated? _____

2) If your patient had a sedentary job, what percentage of time during an eight-hour workday should the legs be elevated? _____%

3) What symptom(s) cause a need to elevate the legs?
_____ edema _____ pain/parasthesia
_____ other: _____

F. While engaging in even occasional standing/walking must your patient use a **cane** or other assistive device for balance? _____ Yes _____ No

G. How many pounds can the patient **lift and carry** in a competitive work situation?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.	_____	_____	_____	_____
10 lbs.	_____	_____	_____	_____
20 lbs.	_____	_____	_____	_____
50 lbs.	_____	_____	_____	_____

H. How often can your patient perform the following waist-level activities?

	Never	Rarely	Occasionally	Frequently
Twist	_____	_____	_____	_____
Stoop (bend)	_____	_____	_____	_____

I. If your patient has significant limitations with **reaching, handling or fingering**, please estimate the percentage of time during an eight-hour workday that your patient can use hands/fingers/arms for the following activities:

HANDS: grasp, turn **FINGERS: fine** **ARMS: reaching**
twist objects **manipulations** **(incl. overhead)**

Right _____% _____% _____%
Left _____% _____% _____%

J. Does your patient exhibit sensitivities to certain **environmental conditions**?
_____ Yes _____ No

If yes, identify conditions to which your patient must avoid even occasional exposure:

_____ latex _____ air conditioning _____ outdoor cold or heat
_____ high humidity _____ cigarette smoke _____ cleaners
_____ dust _____ perfumes/colognes _____ food odors
_____ fumes/gases _____ other: _____

K. Please estimate, on average, how often your patient is likely to be **absent** from work as a result of impairment(s) and treatment:

_____ never/less than once a month _____ about four days a month
_____ about once or twice a month _____ more than four days a month
_____ about three days a month

Signed: _____ Date: _____

Print Name: _____

Address: _____

Re: _____ SSN: _____

To determine your patient's ability to do work-related activities on a day-to-day basis in a regular work setting, please give your opinion - based on your examination - of how your patient's mental/emotional capabilities are affected by the impairment(s). Consider the medical history, the chronicity of findings (or lack thereof), and the expected duration of any work-related limitations, but not your patient's age, sex or work experience.

- **Seriously limited, but not precluded** means ability to function in this area is seriously limited and less than satisfactory, but not precluded. This is a substantial loss of ability to perform the work-related activity.
- **Unable to meet competitive standards** means your patient cannot satisfactorily perform this activity independently, appropriately, effectively and on a sustained basis in a regular work setting.
- **No useful ability to function**, an extreme limitation, means your patient cannot perform this activity in a regular work setting.

Mental Abilities and Aptitude Needed to Work

		Unlimited or Very Goodbut	Limited, satisfactory	limited, but not precluded	Seriously meet competitive standards	Unable to ability	No useful to function
1.	Interact appropriately with general public.	_____	_____	_____	_____	_____	_____
2.	Understand, remember and carry out very short and simple instructions	_____	_____	_____	_____	_____	_____
3.	Maintain attention and concentration for extended periods.	_____	_____	_____	_____	_____	_____
4.	Complete a normal workday and workweek without interruption from physically and/or psychologically based symptoms.	_____	_____	_____	_____	_____	_____
5.	Perform routine repetitive work at a consistent pace without an unreasonable number and length of rest periods.	_____	_____	_____	_____	_____	_____
6.	Deal with normal work stress.	_____	_____	_____	_____	_____	_____

Signature: _____ Date: _____