

PULMONARY MEDICAL SOURCE STATEMENT

From: _____

Re: _____ (Name of Patient)

_____ (Social Security No.)

Please answer the following questions concerning your patient's impairments. *Attach relevant treatment notes, radiologist reports, laboratory and test results as appropriate.*

1. Frequency and length of contact: _____

2. Diagnoses: _____

3. Identify the clinical findings, laboratory and pulmonary function test results that show your patient's medical impairments: _____

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Rhonchi | <input type="checkbox"/> Episodic pneumonia |
| <input type="checkbox"/> Orthopnea | <input type="checkbox"/> Edema | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Episodic acute asthma | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Episodic acute bronchitis | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Other symptoms: _____ | | |

5. If your patient has acute asthma attacks,

a. Identify the precipitating factors:

- | | |
|--|---|
| <input type="checkbox"/> Upper respiratory infection | <input type="checkbox"/> Emotional upset/stress |
| <input type="checkbox"/> Allergens | <input type="checkbox"/> Irritants |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Cold air/change in weather |
| <input type="checkbox"/> Aspirin/tartazine | <input type="checkbox"/> Foods |

b. Characterize the nature and severity of your patient's attacks: _____

c. How often does your patient have asthma attacks? _____

d. How long is your patient incapacitated during an average attack? _____

6. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? Yes No

If no, please explain: _____

For this and other questions on this form, “rarely” means 1% to 5% of an 8-hour working day; “occasionally” means 6% to 33% of an 8-hour working day; “frequently” means 34% to 66% of an 8-hour working day.

f. How many pounds can your patient lift and carry in a competitive work situation?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

g. How often can your patient perform the following activities?

	Never	Rarely	Occasionally	Frequently
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stoop (bend)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch/ squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

h. State the degree to which your patient should avoid the following:

ENVIRONMENTAL RESTRICTIONS	NO RESTRICTIONS	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Extreme cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extreme heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wetness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigarette smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perfumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soldering fluxes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Solvents/cleaners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fumes, odors, gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List other irritants: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

i. How much is your patient likely to be “*off task*”? That is, what percentage of a typical workday would your patient’s symptoms likely be severe enough to interfere with *attention and concentration* needed to perform even simple work tasks?

- 0% 5% 10% 15% 20% 25% or more

j. To what degree can your patient tolerate work stress?

- | | |
|--|--|
| <input type="checkbox"/> Incapable of even "low stress" jobs | <input type="checkbox"/> Capable of low stress jobs |
| <input type="checkbox"/> Moderate stress is okay | <input type="checkbox"/> Capable of high stress work |

Please explain the reasons for your conclusion: _____

k. Are your patient's impairments likely to produce "good days" and "bad days"?
 Yes No

If yes, assuming your patient was trying to work full time, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments or treatment:

- | | |
|---|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> About three days per month |
| <input type="checkbox"/> About one day per month | <input type="checkbox"/> About four days per month |
| <input type="checkbox"/> About two days per month | <input type="checkbox"/> More than four days per month |

11. Are your patient's impairments (physical impairments plus any emotional impairments) ***reasonably consistent*** with the symptoms and functional limitations described in this evaluation? Yes No

12. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

Date

Signature

Printed/Typed Name: _____

Address: _____

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