Appendix C
Physician's FMS Disability Questionnaire

Patient: _____

Soc. Sec.#: _____

How long have you known this patient _____

Frequency of contact _____

Does your patient meet the ACR Criteria for FMS?

Yes No

List any other diagnosed impairments:

_____

Have your patient's impairments lasted or are they expected to last at least 12 months?

Yes No

Clinical Findings, Lab/Test Results

_____

If your Patient has Pain, where is it located?

_____

Describe the frequency and severity of your patient's pain:

_____

Circle any factors that precipitate pain:

Weather	Fatigue	Repetitive Motion
Stress	Cold	Hormonal Changes
Humidity	Heat	Static Position
Allergies	Other: _____	

Is your patient a malingerer? Yes No

What side effects of patient's pain medications have implications for working? For example, drowsiness, diarrhea, stomach upset, dizziness, etc.

_____

What functional limitations would your patient have in a work situation?

_____

Does your patient need a job that allows shifting positions at will from standing, sitting, walking, etc.?

Yes No

Will your patient sometimes need to lie down at unpredictable intervals during a work shift?

Yes No

While standing/walking, must your patient use a cane or other assistive device?

Yes No Sometimes

On average, how often do you anticipate that your patient's impairments and/or treatments would cause the patient to be absent from work?

Never Less than once/mo. More than 3 times/mo.

Describe any other limitations that would affect this patient's ability to work at a regular job on a sustained basis:

_____

_____

Signed: _____ Date: _____

Print/Type Name:

_____Phone: _____

Address: _____

_____