Residual Functional Capacity Form/Medical Opinion Statement

Patient Name: *Nona Mecklenburg* **Date of Birth:** 10/12/1963
Social Security #: 999-99-9876

Please respond to the following questions regarding your patient's ability to perform work-related physical activities. When answering the questions, please be specific with regards to what evidence in your patient's records supports your opinion. This will be used as medical evidence for a Social Security disability claim or a private long-term disability claim.

Section A: Medical History

1. When did you begin treating the patient?

    May 5, 2023

2. How often do you see the patient?

    Every two to three months.

3. What is your diagnosis of the patient's medical impairment(s)?

    I have diagnosed Ms. Mecklenburg with age-related "dry" macular degeneration in both eyes, resulting in a significant loss of vision.

4. What is your prognosis for the patient (good, fair, poor)?

    Poor. Macular degeneration is a progressive condition that cannot be reversed with surgical intervention, only slowed with treatment. Ms. Mecklenburg's macular degeneration has already progressed a great deal, and she will eventually lose her remaining vision (barring a significant medical breakthrough).

5. Please list the objective medical findings that you use to support your diagnosis:

    I have administered several eye examinations to Ms. Mecklenburg that support a finding of macular degeneration, such as the Amsler grid test, fluorescein angiography, and optical coherence tomography.

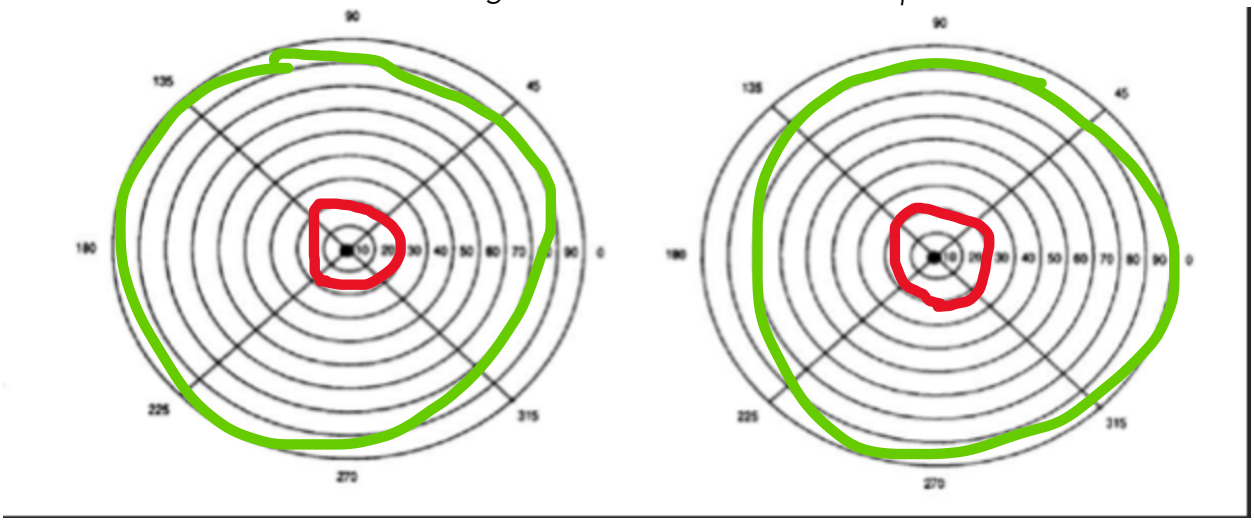
6. Please describe any treatment the patient has completed so far and the results of the treatment:

I have prescribed several supplements that have been shown by several age-related eye disease studies to potentially slow down macular degeneration. These include vitamins such as lutein, zinc, copper, and vitamins C & E. Ms. Mecklenburg has also complied with recommended dietary changes intended to help slow the progress of this disease.

Section B: Signs and Symptoms

7. Please identify the medical signs, present on physical examination, of your patient's impairment(s):

Ophthalmological tests show Ms. Mecklenburg has a significant loss of central visual acuity and contraction of the visual field in both eyes as a result of macular degeneration. Her corrected vision is 20/200 in both eyes, and she has an extremely narrowed visual field of 20 degrees in diameter at the widest point of fixation.



In the above diagram, the green circle represents an average visual field, while the red circle represents Ms. Mecklenburg's current greatly reduced visual field.

8. Please identify the symptoms of your patient's impairment(s):

Ms. Mecklenburg reports blurred vision and an inability to distinguish between shapes and faces, especially during twilight conditions or at night. She sees straight lines as curving or wavy, and reports having dark gaps in her field of vision.

Section C: Functional Limitations

9. Does your patient have limitations in their ability to stand? __✓_ Yes _____No

If yes, please circle the number that best describes the total amount your patient can stand in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can stand at one time before they need to sit down (in minutes or hours)?

Ms. Mecklenburg can experience dizziness if she stands for more than one hour at a time.

10. Does your patient have limitations in their ability to walk? __✓_ Yes _____No

If yes, please circle the number that best describes the total amount your patient can walk in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can walk at one time before they need to sit down (in minutes, hours, or distance)?

Ms. Mecklenburg has difficulty navigating due to her visual impairment. She is prone to tripping, bumping into stationary objects, and avoiding common workplace potential hazards such as electrical cords or spills, even with appropriate signage.

Does your patient require an ambulatory aid, such as a walker or cane?
__✓_ Yes _____No

12. Does your patient have limitations in their ability to sit? __✓_ Yes _____No

If yes, please circle the number that best describes the total amount your patient can sit in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can sit at one time before they need to get up (in minutes or hours)?

While Ms. Mecklenburg does not have any back issues that limit her ability to sit or that cause pain, she would have difficulty with many sit-down jobs that require her to use a computer, as she would have trouble looking at the screen.

13. Does your patient have limitations on lifting and carrying? _____Yes _✓_ No

If yes, please circle the number that best describes the heaviest amount, in pounds, that your patient can lift or carry *occasionally* (up to 1/3 of the workday):

Less than 10# 10# 20# 50# 100#

Please circle the number that best describes the heaviest amount, in pounds, that your patient can lift or carry *frequently* (up to 2/3 of the workday):

Less than 10# 10# 20# 50# 100#

14. Does your patient need to be able to change positions at will? _✓_ Yes _____No

If yes, how often do you think your patient will need to shift positions during the workday?

Ms. Mecklenburg will need to change her head positions frequently in order to avoid eye strain.

15. Does your patient need to be able to lie down during the day? __✓_Yes ____No

If yes, how often do you think your patient will need to lie down during the day and for how long?

Ms. Mecklenburg should be allowed to rest with her eyes closed for ten minutes every hour.

16. Does your patient need to be able to elevate their legs? ____Yes __✓_ No

If yes, how long does your patient need to elevate their legs for and at what height (e.g., at waist level)?

Mr. Summers should be able to elevate his legs (or lie down) for at least 45 minutes every four hours to relieve pain.

17. Please check the box that best describes how often your patient can perform the following actions in an 8-hour workday:

	Rarely or Never (very little, if at all)	Occasionally (up to 1/3 of the day)	Frequently (1/3-2/3 of the day)
Twist	☐	☒	☐
Bend	☒	☐	☐
Crouch	☒	☐	☐

Climb stairs	☒	☐	☐
Climb ladders	☒	☐	☐
Kneel	☒	☐	☐
Crawl	☒	☐	☐
Balance	☐	☒	☐

18. Does your patient have additional visual limitations? _✓__Yes ____No

If yes, please check the box that best describes how often your patient can perform activities involving the following:

	Rarely or Never (very little, if at all)	Occasionally (up to 1/3 of the day)	Frequently (1/3-2/3 of the day)
Discerning colors	☒	☐	☐
Depth perception	☒	☐	☐
Far visual acuity	☒	☐	☐
Near visual acuity	☒	☐	☐
Peripheral vision	☒	☐	☐

19. Are your patient's symptoms exacerbated by exposure to certain environmental conditions? _✓_ Yes _____No

If yes, please check the box that best describes how often your patient should come into contact with the following factors:

	Avoid All Exposure	Avoid Moderate Exposure	Avoid Concentrated Exposure	No Restrictions
Extreme cold	☐	☐	☒	☐
Extreme heat	☐	☐	☒	☐
Wetness	☐	☐	☒	☐
Humidity	☐	☐	☒	☐
Noise	☐	☐	☐	☒
Fumes or gases	☐	☐	☒	☐
Hazards	☒	☐	☐	☐
Heights	☒	☐	☐	☐

20. Does your patient experience pain? ____ Yes _✓_ No

If yes, please describe the location, intensity, and frequency of the pain:

21. Do your patient's symptoms affect the ability to concentrate or maintain attention? _✓_ Yes _____No

Ms. Mecklenburg needs extra time to perform tasks that involve visual acuity such as reading, doing mathematical calculations, and distinguishing between small shapes.

If yes, please circle the percentage that best reflects how much of the workday these symptoms would be severe enough to interfere with tasks:

5% 10% 15% (20%) 25% Over 25%

22. Do your patient's symptoms result in "good days" and "bad days"? _____Yes __✓_ No

23. Would your patient's symptoms or treatment result in absences from work? _✓_Yes _____No

If yes, please circle the amount that best represents how often your patient would miss work per month:

Less than one day One day (Two days) Three days More than three days

Section D: Professional Observations

24. Has your patient cooperated with your treatment recommendations? __✓_ Yes ____ No

If not, please explain why your patient was unable to follow the recommended treatment:

25. Does your patient have a history of drug or alcohol abuse? _____ Yes __✓_ No

If yes, would your patient's symptoms exist or persist despite drug or alcohol use? _____ Yes _____No

26. Does your patient exaggerate symptoms? _____ Yes _✓_ No

27. Do you expect the patient's limitations to last at least one year? _✓_ Yes _____No

28. On what date did these limitations begin?

Ms. Mecklenburg has had these limitations since she first established care with my practice on May 5, 2023.

29. In your opinion, are your patient's limitations reasonably consistent with the objective medical evidence and physical evaluations as a whole? _✓_ Yes _____No

Doctor's Name and Signature: Jessica Kiwanuka, M.D. **Date:** April 14, 2025

Jessica Kiwanuka, MD

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