Residual Functional Capacity Form/Medical Opinion Statement

Patient Name: *George Maeda* **Date of Birth:** *11/15/1969*
Social Security #: *999-00-0009*

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?

    December 9, 2019

2. How often do you see the patient?

    Every six months.

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

    Mr. Maeda has profound sensorineural presbycusis (age-related hearing loss).

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

    Fair. Mr. Maeda received a cochlear implantation in 2022 and has been actively engaged in rehabilitative treatment since then, but is likely to retain significant hearing loss despite some improvements in speech recognition.

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

    Pure-tone air conduction testing in 2020 showing an average hearing threshold of 90 decibels (dB) in his better (right-sided) ear. Pure-tone bone conduction testing in 2021 showing an average of 60 db in the same ear. Word recognition testing in 2023 of 40% in the better ear.

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

treatment:

    Mr. Maeda has a cochlear implant and also uses a hearing aid.

Section B: Signs and Symptoms

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

Mr. Maeda performs poorly on audiometric tests such as word recognition and identifying different pitches of tones in his ears, often misidentifying words or failing to recognize when tones are being played.

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

Mr. Maeda reports ringing in his ears (tinnitus) and difficulty discerning even loud speech. He frequently requests that I repeat myself and appears frustrated as a result of his trouble hearing other people.

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)?

_____

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)?

_____

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)?

_____

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? _____

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? _____

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)? _____

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 limitations in the upper extremities? _____ Yes _✓_No

If yes, please check the box that best describes how often your patient can use their arms, hands, and fingers to perform the following activities:

	Rarely or Never (very little, if at all)	Occasionally (up to 1/3 of the day)	Frequently (1/3-2/3 of the day)
Reaching overhead	☐	☐	☐
Reaching laterally	☐	☐	☐
Handling	☐	☐	☐
Fingering	☐	☐	☐
Feeling	☐	☐	☐
Grasping	☐	☐	☐

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

Mr. Maeda has significant tinnitus that frequently interferes with his thought processes and causes distractions. He often needs to ask others to repeat themselves which can double the time it takes for him to communicate.

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?

They existed on or before the date of Mr. Maeda's cochlear implantation, which occurred on February 6, 2022.

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: Sergio Fowler, M.D., Au.D. **Date:** November 4, 2024

Sergio Fowler

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