MEDICAL SOURCE STATEMENT
FIBROMYALGIA

***Instructions/ Disclosure*:** This form is intended to be completed by a treating medical provider for the listed patient. If you are unable to provide an answer to a question, please mark "N/A" or leave it blank. Please note this information will only be used in strict confidence for evaluation of the Patient's claim for disability by the Social Security Administration and will not be used in any other way. Thank you.

PATIENT INFORMATION

Last Name:	*First Name:*	*Date of Birth:*

PROVIDER & CLINIC INFORMATION

Provider Name:		*Area(s) of Practice:*
Clinic Name:		
Address:	*Office Number:*	*Fax Number:*
Date of Patient's First Exam:	*Date of Patient's Most Recent Exam:*	
Today's Date:		

Please complete the following questions based on your professional judgement regarding the patient's physical and cognitive limitations related to their diagnosed medical condition(s).

1. **Frequency and length of contact: _____**

2. **Does your patient meet the 1990 American College of Rheumatology Criteria for the Classification of Fibromyalgia (which includes tender point criteria)? Yes ☐ No ☐**

   2a. If no, does your patient meet the 2010 American College of Rheumatology Preliminary Diagnostic Criteria for Fibromyalgia (which does not include tender point criteria)?

   Yes ☐ No ☐

3. **Identify your patient's symptoms, signs, and associated conditions:**

- ☐ History of widespread pain > 3 months
- ☐ 11 of 18 specific tender points — see page 3
- ☐ Cognitive dysfunction ("fibro fog")
- ☐ Irritable Bowel Syndrome
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Frequent severe headaches
- ☐ Dizziness
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Frequent urination
- ☐ Insomnia
- ☐ Pain in upper abdomen
- ☐ Raynaud's Phenomenon
- ☐ Hives or welts
- ☐ Ringing in the ears
- ☐ Oral ulcers
- ☐ Change in taste
- ☐ Dry eyes
- ☐ Shortness of breath
- ☐ Loss of appetite
- ☐ Hearing difficulties
- ☐ Frequent urination
- ☐ Severe fatigue
- ☐ Depression
- ☐ Anxiety disorder
- ☐ Waking unrefreshed

- ☐ Numbness or tingling
- ☐ Abdominal pain/cramps
- ☐ Constipation
- ☐ Nausea
- ☐ Nervousness
- ☐ Chest pain
- ☐ Blurred vision
- ☐ Fever
- ☐ Diarrhea
- ☐ Dry mouth
- ☐ Itching
- ☐ Wheezing
- ☐ Vomiting
- ☐ Heartburn
- ☐ Loss of taste
- ☐ Seizures
- ☐ Sun sensitivity
- ☐ Easy bruising
- ☐ Hair loss
- ☐ Bladder spasms
- ☐ Irritable bladder syndrome
- ☐ Gastroesophageal Reflux Disorder (GERD)
- ☐ Chronic Fatigue Syndrome
- ☐ Restless leg syndrome
- ☐ Temporomandibular Joint Disorder (TMJ)
- ☐ Involuntary weight loss
- ☐ Interstitial cystitis
- ☐ Migraines
- ☐ Dysmenorrhea
- ☐ Multiple Chemical Sensitivity
- ☐ Carpal Tunnel Syndrome
- ☐ Panic attacks
- ☐ Malaise [1]
- ☐ Other:

*Malaise is defined as frequent feelings of illness, bodily discomfort, or lack of well-being that result in significantly reduced physical activity or mental function

4. **Other diagnosed conditions:**

5. **Were other disorders that could cause repeated manifestations of symptoms, signs or concurrent conditions *excluded*? (Such disorders include rheumatologic disorders, myofascial pain syndrome, polymyalgia rheumatica, chronic Lyme disease, and cervical hyperextension-associated or hyperflexion-associated disorders.)**

Yes ☐ **No** ☐

6. **Identify the location of pain including, where appropriate, an indication of right or left side or bilateral areas affected:**

	RIGHT	LEFT	BILATERAL
☐ **Lumbosacral Spine**			
☐ **Cervical Spine**			
☐ **Thoracic Spine**			
☐ **Chest**			
☐ **Shoulders**	☐	☐	☐
☐ **Arms**	☐	☐	☐
☐ **Hands/fingers**	☐	☐	☐
☐ **Hips**	☐	☐	☐
☐ **Legs**	☐	☐	☐
☐ **Knees/ankles/feet**	☐	☐	☐

6a. Describe the nature, frequency, and severity of your patient's pain:

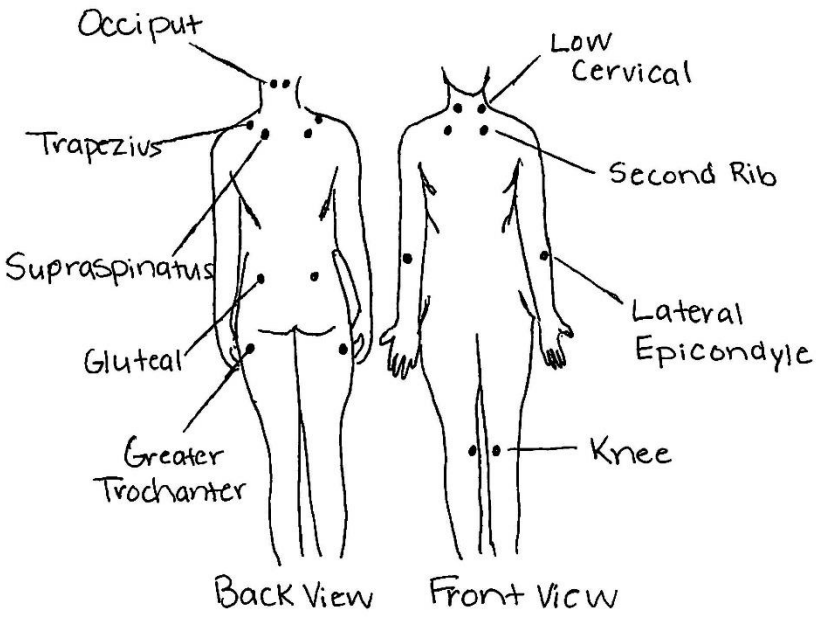
6b. Identify any factors that precipitate pain:

- ☐ Changing weather
- ☐ Hormonal changes
- ☐ Fatigue
- ☐ Stress
- ☐ Movement/Overuse
- ☐ Stress
- ☐ Cold
- ☐ Static Position

7. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?

Yes ☐ **No** ☐

8. Circle your patient's tender points:



9. Describe the treatment and response including any side effects of medication that may have implications for working, e.g., drowsiness, dizziness, nausea, etc.:

10. What is your patient's prognosis?

11. Has your patient's fibromyalgia lasted, or can it be expected to last, at least 12 months? Yes ☐ **No** ☐

12. As a result of your patient's impairments, estimate your patient's functional limitations if your patent were paced in a *competitive work situation:*

a. Does your patient have the stamina and endurance to work an easy job 8 hours per day, 5 days per week (with normal breaks every two hours)? Yes ☐ No ☐

If no, please explain the reasons for your conclusion:

b. Does your patient need a job that permits shifting positions *at will* from sitting, standing, or walking?

Yes ☐ No ☐

c. Does your patient need to include periods of walking around during an 8-hour working day?

Yes ☐ No ☐

1) If yes, approximately how often must your patient walk? (Please circle one)

1 5 10 15 20 30 45 60 90

Minutes

2) How long must your patient walk each time?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

Minutes

d. In addition to normal breaks every two hours, will your patient sometimes need to take unscheduled breaks during a working day? Yes ☐ No ☐

If yes, 1) approx. how ***often*** do you think this will happen? _____

2) approx. how ***long*** (on average) which each break last? _____

3) what symptoms cause a need for breaks?

- ☐ Muscle weakness
- ☐ Chronic fatigue
- ☐ Other:
- ☐ Pain / paresthesia, numbness
- ☐ Adverse effects of medication

e. With prolonged sitting, should your patient's leg(s) 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 8-hour day should the legs be elevated? _____%

3) what symptoms cause a need to elevate leg(s)? _____

Does your patient have significant limitations with reaching, handling, or fingering? Yes☐ No☐

If yes, please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn **Twist Objects**	FINGERS: Fine **Manipulations**	ARMS: Reaching **In Front of Body**	ARMS: Reaching **Overhead**
Right:	%	%	%	%
Left:	%	%	%	%

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

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

- ☐ Incapable of even "low stress" work
- ☐ Capable of moderate stress — normal work
- ☐ Capable of low stress work
- ☐ Capable of high stress work

g. 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 because of the impairments:

- ☐ Never
- ☐ About one day per month
- ☐ About two days per month
- ☐ About three days per month
- ☐ About four days per month
- ☐ More than four days per month

h. Indicate to what degree the following functional limitations exist because of your patient's impairments.

Note: **Marked** means more than moderate but less than extreme. A marked limitation may arise when several activities or functions ae impaired or even when only one is impaired so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, effectively, and one a sustained basis.

Functional Limitation:

A.	Limitation of activities of daily living	None or Mild	Moderate	Marked	Extreme
B.	Limitation in maintaining social functioning	None or Mild	Moderate	Marked	Extreme
C.	Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace	None or Mild	Moderate	Marked	Extreme

13. **Are your patient's impairments (physical impairments plus any emotional impairments) as demonstrated by signs, clinical findings, and laboratory or test results *reasonably consistent* with the symptoms and functional limitations described above in this evaluation?**

Yes ☐ **No** ☐

If no, please explain:

14. **Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases, or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis?**

_____ _____

Provider's Name and Designation ***Provider's Specialty***

_____ _____

Provider Signature ***Date***

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PRIVACY ACT NOTICE: *The information requested on this form will be used in deciding this patient's Social Security Disability Claim. Failure to complete this form may result in a delay in processing the claim. Information furnished on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with Federal laws requiring the exchange of information between Social Security and other agencies.*