

Residual Functional Capacity Assessment

Medical Consultant Summary Dictation

CLAIMANT: MARY SMITH
SSN: 555-55-5555

This 22-year-old female alleges disability to 7/21/01 due to polymyalgia rheumatica, congestive heart failure, hypertension, arthritis, thyroid problems and sleep apnea.

Her ADL's completed 01/01/01 notes she lives alone, does her own personal care needs, prepares simple meals, does one load of laundry a day, drives short distances, can walk maybe one-half block, stand 5-10 minutes, climb no stairs, can sit one-half hour and then her back and hips hurt and she has to move around. Her symptoms are arthritic pain in the knees, feet, back, neck, shoulders, hands, shortness of breath, fatigue, high blood pressure, poor circulation. States that she "never feels good."

Medical evidence notes that claimant has had a left thyroid lobectomy for multinodular goiter. A thyroid uptake scan in October of '01 showed multinodular goiter on the right. She was seen in consultation but no surgery was recommended.

She underwent a cardiac catheterization in November of '01 which showed essentially negative findings. She did have a left ventricular ejection fraction of 70%.

She was hospitalized briefly in Midlands Hospital in December of '01 with hypertension and venous stasis which was felt secondary to her use of her Vioxx. Also found to have elevated blood sugar.

In March of '01 she was seen in the emergency room for dizziness. At that time EKG, chest x-ray, head CT and cardiac monitor were really noncontributory and she was diagnosed with vertigo and hypokalemia.

Follow-up at Nebraska Heart Institute on 01/01/01 noted that her weight was 999 lbs., her blood pressure 101/99. She had no murmur. She did have 1+ edema. The impression was that lower extremity edema is not likely cause from cardiac abnormalities.

She was hospitalized 01/01/01 to 01/01/01 at Any Hospital with near syncope. Chest x-ray was negative. Pulmonologist was consulted and felt that she had some element of sleep apnea and she was started on CPAP. An echo showed ejection fraction of 60%. The cardiologist felt that she had significant diastolic dysfunction which contributed to her edema. She was diagnosed with vasovagal syncope.

Follow-up on May 1 noted that she was not feeling better and gets shortness of breath with doing anything. Her weight was 999 lbs. She had regular S1 and S2 with no murmur or gallop and had only a trace to 1+ edema.

A sleep study in June of '01 diagnosed obstructive sleep apnea and periodic limb movements and CPAP was recommended.

She was hospitalized 01/01/01 to 01/01/01 at Anytown with an admitting diagnosis of probable acute MI, however, emergency cath showed no evidence of MI and her arteries were described as surprisingly normal. Her blood pressure was markedly elevated. Final diagnosis was noncardiac chest pain and severe hypertension.

Claimant underwent a CE by her primary care physician, Dr. Anydoc, on 01/01/01 with chief complaints severe fatigue, muscle and joint aches which have increased over the past year. It was noted that she had probable polymyalgia rheumatica and this had seemed to respond to low dose Prednisone. Also a history of hypertension, degenerative arthritis of the knees. States she can walk a half block then has to stop secondary to lack of energy. She complains of severe pain in the knees, right greater than left, as well as neck and low back pain, and has severe difficulty with bending, squatting, lifting, stooping or prolonged sitting. States that the range of motion of her neck, back, knees severely limited secondary to pain. On physical her height was 99 ½", weight was 999 lbs., blood pressure 101/99, neck had some tenderness over the anterolateral aspects. There were no murmurs. Lungs were clear. She had no edema. She did have increased muscle tone of the paralumbar musculature and had crepitace of both knees right greater than left. Her lumbar spine allowed forward flexion to 50 degrees, extension 20 degrees. Lateral flexion on the left 15 degrees. Knee flexion was 80 degrees on the right and 90 degrees on the left. Cervical flexion was 30 degrees, extension 20 degrees. Her gait was slow and wide based. She had no joint swelling. X-ray of the right knee showed tricompartmental degenerative changes especially in the medial compartment and the cervical spine showed some decreased joint space at C4-5.

Claimant has medically determinable impairments of 1. Degenerative arthritis of the right knee, 2. Obesity, 3. Hypertension, 4. History of congestive heart failure, 5. Diabetes, 6. Sleep apnea. The impairments appear severe but do not meet or equal a listing. The impairments can reasonably produce significant limitations in claimant's ability to stand or walk for prolonged periods or to do repetitive manipulations requiring flexion and extension of the right knee secondary to arthritis. She also would have limitations of kneeling, crouching and crawling. I do not find documented evidence supporting the diagnosis of polymyalgia rheumatica. I do not find significant limitations related to her diabetes or her thyroid multinodular goiter. She does have marked obesity. She does have significant hypertension and does have documented sleep apnea. Therefore her allegations appear partially credible, and she does appear limited as per RFC with EOD equaling AOD.

I affirm that the above transcription was made from the recorded voice of Dr. Doolittle.