Compensation and Pension Record Interchange (CAPRI)

CAPRI Compensation and Pension Worksheet Module (CPWM) Templates and AMIE Worksheet Disability Benefits Questionnaires (DBQs)

Release Notes
Patch: DVBA*2.7*173

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Office of Enterprise Development
Management & Financial Systems

Preface

Purpose of the Release Notes

The Release Notes document describes the new features and functionality of patch DVBA*2.7*173. (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs).

The information contained in this document is not intended to replace the CAPRI User Manual. The CAPRI User Manual should be used to obtain detailed information regarding specific functionality.

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1. Purpose

The purpose of this document is to provide an overview of the enhancements specifically designed for Patch DVBA*2.7*173.

Patch DVBA *2.7*173 (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs) introduces enhancements and updates made to the AUTOMATED MED INFO EXCHANGE (AMIE) V 2.7 package and the Compensation & Pension Record Interchange (CAPRI) application in support of the new Compensation and Pension (C&P) Disability Benefits Questionnaires (DBQs).

2. Overview

Veterans Benefits Administration Veterans Affairs Central Office (VBAVACO) has approved implementation of the following new Disability Benefits Questionnaires:

- **DBQ AMPUTATIONS**
- **DBQ ARTERY AND VEIN CONDITIONS (VASCULAR DISEASES INCLUDING VARICOSE VEINS)**
- **DBQ ELBOW AND FOREARM CONDITIONS**
- **DBQ FLATFOOT (PES PLANUS)**
- **DBQ FOOT MISCELLANEOUS (OTHER THAN FLATFOOT PES PLANUS)**
- **DBQ HAND AND FINGER CONDITIONS**
- **DBQ HIP AND THIGH CONDITIONS**
- **DBQ MUSCLE INJURIES**
- **DBQ TEMPOROMANDIBULAR JOINT (TMJ) CONDITIONS**
- **DBQ WRIST CONDITIONS**

NOTE: In order to have a successful installation it is first required to install the associated Patch DVBA*2.7*166 before this patch is installed.

3. Associated Remedy Tickets & New Service Requests

There are no Remedy tickets or New Service Requests associated with patch DVBA*2.7*173.

4. Defects Fixes

There are no CAPRI DBQ Templates or AMIE – DBQ Worksheet defects fixes associated with patch DVBA*2.7*173.

5. Enhancements

This section provides an overview of the modifications and primary functionality that will be delivered in Patch DVBA*2.7*173.

5.1 CAPRI – DBQ Template Additions

This patch includes adding four new CAPRI DBQ Templates that are accessible through the Compensation and Pension Worksheet Module (CPWM) of the CAPRI GUI application.

- **DBQ AMPUTATIONS**
- **DBQ ARTERY AND VEIN CONDITIONS (VASCULAR DISEASES INCLUDING VARICOSE VEINS)**
- **DBQ ELBOW AND FOREARM CONDITIONS**
- **DBQ FLATFOOT (PES PLANUS)**
- **DBQ FOOT MISCELLANEOUS (OTHER THAN FLATFOOT PES PLANUS)**
- **DBQ HAND AND FINGER CONDITIONS**
- **DBQ HIP AND THIGH CONDITIONS**
- **DBQ MUSCLE INJURIES**
- **DBQ TEMPOROMANDIBULAR JOINT (TMJ) CONDITIONS**
- **DBQ WRIST CONDITIONS**

5.2 CAPRI – DBQ Template Modifications

There are no CAPRI DBQ Templates modifications associated with patch DVBA*2.7*173.

5.3 AMIE–DBQ Worksheet Additions

VBAVACO has approved the following new AMIE –DBQ Worksheets that are accessible through the Veterans Health Information Systems and Technology Architecture (VistA) AMIE software package.

- **DBQ AMPUTATIONS**
- **DBQ ARTERY AND VEIN CONDITIONS (VASCULAR DISEASES INCLUDING VARICOSE VEINS)**
- **DBQ ELBOW AND FOREARM CONDITIONS**
- **DBQ FLATFOOT (PES PLANUS)**
- **DBQ FOOT MISCELLANEOUS (OTHER THAN FLATFOOT PES PLANUS)**
- **DBQ HAND AND FINGER CONDITIONS**
- **DBQ HIP AND THIGH CONDITIONS**
- **DBQ MUSCLE INJURIES**
- **DBQ TEMPOROMANDIBULAR JOINT (TMJ) CONDITIONS**
- **DBQ WRIST CONDITIONS**

This patch implements the new content for the AMIE C&P Disability Benefit Questionnaire worksheets, which are accessible through the VISTA AMIE software package.

5.4 AMIE–DBQ Worksheet Modifications

There are no AMIE- DBQ Worksheets modifications associated with patch DVBA*2.7*173.

6. Disability Benefits Questionnaires (DBQs)

The following section illustrates the content of the new questionnaires included in Patch DVBA*2.7*173.

6.1. DBQ Amputations

Name of patient/Veteran: _____SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

NOTE: If there is limited motion or instability in the joint above the amputation site, also complete a Questionnaire for the specific joint. If there are associated muscle injuries, also complete the Muscle Injury Questionnaire.

1. Diagnosis
Has the Veteran had any amputations?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to amputations:
Amputation #1: _____
ICD code: _____
Date of amputation: _____

Amputation #2: _____
ICD code: _____
Date of amputation: _____

Amputation #3: _____
ICD code: _____
Date of amputation: _____

If additional amputations exist, list using above format: _____

2. Medical history
a. Describe the history (including etiology and course) of each amputation listed above: _____

b. Dominant hand:
☐ Right ☐ Left ☐ Ambidextrous

3. Amputation sites
Indicate affected sites:
- ☐ Upper extremities (not including fingers)
- ☐ Fingers
- ☐ Lower extremities (not including toes)
- ☐ Toes

For all checked sites, complete the corresponding sections below.

4. Upper extremities (not including fingers)
a. Does the Veteran have an amputation of either arm?
☐ Yes ☐ No

If yes, indicate site and side affected (check all that apply):

☐ Below insertion of deltoid
☐ Right ☐ Left ☐ Both
☐ Above insertion of deltoid
☐ Right ☐ Left ☐ Both
☐ Disarticulation
☐ Right ☐ Left ☐ Both

b. Does the amputation site allow the use of a suitable prosthetic appliance?

☐ Yes ☐ No

If yes, indicate side that allows use of suitable prosthetic appliance: ☐ Right ☐ Left ☐ Both

c. Does the Veteran have an amputation of either forearm?

☐ Yes ☐ No

If yes, indicate site and side affected (check all that apply):

☐ Amputation below insertion of pronator teres
☐ Right ☐ Left ☐ Both
☐ Amputation above insertion of pronator teres
☐ Right ☐ Left ☐ Both

5. Fingers

a. Does the Veteran have an amputation of either thumb?

☐ Yes ☐ No

If yes, indicate site and side affected (check all that apply):

☐ Amputation at the distal joint or through the distal phalanx
☐ Right ☐ Left ☐ Both
☐ Amputation at the metacarpophalangeal joint or through the proximal phalanx
☐ Right ☐ Left ☐ Both
☐ Amputation with metacarpal resection
☐ Right ☐ Left ☐ Both

b. Does the Veteran have an amputation of any fingers?

☐ Yes ☐ No

If yes, indicate site and side affected (check all that apply):

☐ Amputation through the middle phalanx or at the distal joint
☐ Right index finger ☐ Left index finger ☐ Both index fingers
☐ Right long finger ☐ Left long finger ☐ Both long fingers
☐ Right ring finger ☐ Left ring finger ☐ Both ring fingers
☐ Right little finger ☐ Left little finger ☐ Both little fingers
☐ Amputation without metacarpal resection, at the proximal interphalangeal joint or proximal thereto
☐ Right index finger ☐ Left index finger ☐ Both index fingers
☐ Right long finger ☐ Left long finger ☐ Both long fingers
☐ Right ring finger ☐ Left ring finger ☐ Both ring fingers
☐ Right little finger ☐ Left little finger ☐ Both little fingers
☐ Amputation with metacarpal resection (more than one-half the bone lost)
☐ Right index finger ☐ Left index finger ☐ Both index fingers
☐ Right long finger ☐ Left long finger ☐ Both long fingers
☐ Right ring finger ☐ Left ring finger ☐ Both ring fingers
☐ Right little finger ☐ Left little finger ☐ Both little fingers

6. Lower extremities (not including the toes)

a. Does the Veteran have an above-knee amputation of the thigh?

☐ Yes ☐ No

If yes, indicate site and side affected (check all that apply):

☐ Amputation to the middle or lower third of thigh
☐ Right ☐ Left ☐ Both
☐ Amputation to the upper third of thigh
☐ Right ☐ Left ☐ Both
☐ Disarticulation with loss of extrinsic pelvic girdle muscles
☐ Right ☐ Left ☐ Both

b. Does the thigh amputation site allow the use of a suitable prosthetic appliance?
☐ Yes ☐ No
If yes, indicate side that allows use of suitable prosthetic appliance: ☐ Right ☐ Left ☐ Both

c. Does the Veteran have a below-knee amputation of the lower leg, including the forefoot?
☐ Yes ☐ No
If yes, indicate site and side affected (check all that apply):
☐ Amputation of forefoot proximal to the metatarsal bones (more than 1/2 of metatarsal loss)
☐ Right ☐ Left ☐ Both
☐ Amputation between the forefoot and knee, permitting prosthesis
☐ Right ☐ Left ☐ Both
☐ Amputation not improvable by prosthesis controlled by natural knee action
☐ Right ☐ Left ☐ Both
☐ Amputation with defective stump and amputation to the thigh recommended
☐ Right ☐ Left ☐ Both

d. Does the lower leg amputation site allow the use of a suitable prosthetic appliance?
☐ Yes ☐ No
If yes, indicate side that allows use of suitable prosthetic appliance: ☐ Right ☐ Left ☐ Both

7. Toes
Does the Veteran have an amputation of any toes?
☐ Yes ☐ No
If yes, indicate site and side affected (check all that apply):
☐ Amputation of toes without removal of the metatarsal head
If checked, indicate site and side affected (check all that apply):

☐ Right great toe	☐ Left great toe	☐ Both great toes
☐ Right 2nd toe	☐ Left 2nd toe	☐ Both 2nd toes
☐ Right 3rd toe	☐ Left 3rd toe	☐ Both 3rd toes
☐ Right 4th toe	☐ Left 4th toe	☐ Both 4th toes
☐ Right little toe	☐ Left little toe	☐ Both little toes

☐ Amputation of toes with removal of the metatarsal head
If checked, indicate site and side affected (check all that apply):

☐ Right great toe	☐ Left great toe	☐ Both great toes
☐ Right 2nd toe	☐ Left 2nd toe	☐ Both 2nd toes
☐ Right 3rd toe	☐ Left 3rd toe	☐ Both 3rd toes
☐ Right 4th toe	☐ Left 4th toe	☐ Both 4th toes
☐ Right little toe	☐ Left little toe	☐ Both little toes

8. Other pertinent physical findings, complications, conditions, signs and/or symptoms
a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
☐ Yes ☐ No
If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs

and/or symptoms related to any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, describe (brief summary): _____

9. Assistive devices

a. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible?
☐ Yes ☐ No
If yes, identify assistive devices used (check all that apply and indicate frequency):

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Brace(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutch(es)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____				
	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition: _____

10. Diagnostic Testing

NOTE: Imaging studies are not required to document amputations.

Are there any significant diagnostic test findings and/or results?
☐ Yes ☐ No
If yes, provide type of test or procedure, date and results (brief summary): _____

11. Functional impact

Do any of the Veteran's amputations impact his or her ability to work?

☐ Yes ☐ No

If yes, describe the impact of each of the Veteran's amputations, providing one or more examples:
_____

12. Remarks, if any: _____

Physician signature: _____ Date: ___
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.2. DBQ Artery and Vein Conditions (Vascular Diseases Including Varicose Veins)

Name of patient/Veteran: _____SSN: _____ ___

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever had a vascular disease (arterial or venous)?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to vascular conditions:
Diagnosis #1: _____
ICD code(s): _____
Date of diagnosis: _____

Diagnosis #2: _____
ICD code(s): _____
Date of diagnosis: _____

Diagnosis #3: _____
ICD code(s): _____
Date of diagnosis: _____

If there are additional diagnoses that pertain to vascular diseases, list using above format: _____

2. Medical history

a. Describe the cause/onset of the Veteran's current vascular condition(s) (brief summary)_____
_____

b. Type of vascular disease condition: (Check all that apply)
- ☐ Section I: Varicose veins and/or post-phlebitic syndrome
- ☐ Section II: Peripheral vascular disease, aneurysm of any large artery (other than aorta), arteriosclerosis obliterans or thrombo-angiitis obliterans (Buerger's Disease)
- ☐ Section III: Aortic aneurysm
- ☐ Section IV: Aneurysm of a small artery
- ☐ Section V: Raynaud's syndrome
- ☐ Section VI: Arteriovenous (AV) fistula, angioneurotic edema or erythromelalgia

If checked, complete appropriate Section I-VI.
Regardless of checked condition, complete Section VII.

Section I: Varicose veins and/or post-phlebitic syndrome

Does the Veteran have varicose veins or post-phlebitic syndrome of any etiology?
☐ Yes ☐ No

If yes, check all symptoms that apply and indicate extremity affected:

☐ Asymptomatic palpable varicose veins	☐ Right	☐ Left	☐ Both
☐ Asymptomatic visible varicose veins	☐ Right	☐ Left	☐ Both
☐ Aching and fatigue in leg after prolonged standing or walking	☐ Right	☐ Left	☐ Both
☐ Symptoms relieved by elevation of extremity	☐ Right	☐ Left	☐ Both
☐ Symptoms relieved by compression hosiery	☐ Right	☐ Left	☐ Both

If yes, check all findings and/or signs that apply and indicate extremity affected:

- ☐ Incipient stasis pigmentation or eczema ☐ Right ☐ Left ☐ Both
- ☐ Persistent stasis pigmentation or eczema ☐ Right ☐ Left ☐ Both
- ☐ Intermittent ulceration ☐ Right ☐ Left ☐ Both
- ☐ Intermittent edema of extremity ☐ Right ☐ Left ☐ Both
- ☐ Persistent edema that is incompletely relieved by elevation of extremity ☐ Right ☐ Left ☐ Both
- ☐ Persistent edema ☐ Right ☐ Left ☐ Both
- ☐ Persistent subcutaneous induration ☐ Right ☐ Left ☐ Both
- ☐ Massive board-like edema ☐ Right ☐ Left ☐ Both
- ☐ Constant pain at rest ☐ Right ☐ Left ☐ Both

Section II: Peripheral vascular disease, aneurysm of any large artery (other than aorta), arteriosclerosis obliterans or thrombo-angiitis obliterans (Buerger's Disease)

a. Has the Veteran ever been diagnosed with: (check all that apply)?

☐ Peripheral vascular disease
☐ Aneurysm of any large artery (other than aorta)
☐ Arteriosclerosis obliterans
☐ Thrombo-angiitis obliterans (Buerger's Disease)
☐ None of the above

If any of the above conditions are checked, answer questions b-f.

b. Has the Veteran undergone surgery for any of these listed conditions?

☐ Yes ☐ No

If yes, type of surgery: _____ Date: _____

c. Has the Veteran undergone any procedure (other than surgery) for revascularization?

☐ Yes ☐ No

If yes, type of procedure: _____ Date: _____

d. Indicate severity of current signs and symptoms and indicate extremity affected: (check all that apply):

- ☐ Claudication on walking more than 100 yards ☐ Right ☐ Left ☐ Both
- ☐ Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour ☐ Right ☐ Left ☐ Both
- ☐ Claudication on walking less than 25 yards on a level grade at 2 miles per hour ☐ Right ☐ Left ☐ Both
- ☐ Persistent coldness of the extremity ☐ Right ☐ Left ☐ Both
- ☐ Diminished peripheral pulses ☐ Right ☐ Left ☐ Both
- ☐ Ischemic limb pain at rest ☐ Right ☐ Left ☐ Both
- ☐ Trophic changes (thin skin, absence of hair, dystrophic nails) ☐ Right ☐ Left ☐ Both
- ☐ 1 or more deep ischemic ulcers ☐ Right ☐ Left ☐ Both

Section III: Aortic aneurysm

a. Has the Veteran ever been diagnosed with an aortic aneurysm?

☐ Yes ☐ No

If yes, has the Veteran had a surgical procedure for an aortic aneurysm?

☐ Yes ☐ No

If yes, indicate type of surgery: _____ Date: _____

b. Does the Veteran currently have an aortic aneurysm?
☐ Yes ☐ No
If yes, indicate severity:
5 centimeters or larger in diameter: ☐ Yes ☐ No
Symptomatic ☐ Yes ☐ No
Precludes exertion ☐ Yes ☐ No

c. Does the Veteran have any post-surgical residuals due to treatment for aortic aneurysm?
☐ Yes ☐ No
If yes, describe: _____

(If there are symptoms or post-surgical residuals, also complete appropriate Questionnaire according to body system affected.)

Section IV: Aneurysm of a small artery

a. Has the Veteran been diagnosed with an aneurysm of a small artery?
☐ Yes ☐ No
If yes, has the Veteran had a surgical procedure for an aneurysm of a small artery?
☐ Yes ☐ No
If yes, indicate type of surgery: _____ Date: _____

b. Does the Veteran currently have an aneurysm of a small artery?
☐ Yes ☐ No
If yes, is the condition symptomatic?
☐ Yes ☐ No
If yes, describe: _____
Also, complete appropriate Questionnaire according to body system affected.

c. Does the Veteran have any post-surgical residuals due to treatment for an aneurysm of a small artery?
☐ Yes ☐ No
If yes, describe: _____

Also, complete appropriate Questionnaire according to body system affected.

Section V: Raynaud's syndrome

a. Does the Veteran have Raynaud's syndrome?
☐ Yes ☐ No
If yes, complete this section.

b. Does the Veteran have characteristic attacks?
☐ Yes ☐ No
If yes, indicate frequency of characteristic attacks:
☐ Less than once a week
☐ 1 to 3 times a week
☐ 4 to 6 times a week
☐ At least daily

NOTE: Characteristic attacks consist of sequential color changes of the digits of one or more extremities lasting minutes to hours, sometimes with pain and paresthesias, and precipitated by exposure to cold or by emotional upsets.

c. Does the Veteran have 2 or more digital ulcers?
☐ Yes ☐ No

d. Does the Veteran have autoamputation of one or more digits?

☐ Yes ☐ No

Section VI: Arteriovenous (AV) fistula, angioneurotic edema or erythromelalgia

a. Does the Veteran have arteriovenous (AV) fistula, angioneurotic edema or erythromelalgia?
☐ Yes ☐ No
If yes, complete this section.

b. Does the Veteran have a traumatic arteriovenous (AV) fistula?
☐ Yes ☐ No
If yes, complete the following:

1. Indicate site of traumatic AV fistula:
   ☐ Right upper extremity ☐ Right lower extremity ☐ Left upper extremity
   ☐ Left lower extremity ☐ Other location, specify _____

2. Indicate findings:
   ☐ Edema
   ☐ Stasis dermatitis
   ☐ Ulceration
   ☐ Cellulitis
   ☐ Enlarged heart
   ☐ Wide pulse pressure
   ☐ Tachycardia
   ☐ High output heart failure

3. Is there more than one traumatic AV fistula?
   ☐ Yes ☐ No
   If yes, provide location and findings for each:_____

c. Does the Veteran have angioneurotic edema?
☐ Yes ☐ No
If yes, indicate severity and frequency of characteristic attacks:
   ☐ Without laryngeal involvement
   ☐ With laryngeal involvement
   ☐ Lasts 1 to 7 days
   ☐ Lasts longer than 7 days
   ☐ Occurs once a year or less
   ☐ Occurs 1 to 2 times a year
   ☐ Occurs 2 to 4 times a year
   ☐ Occurs 5 to 8 times a year
   ☐ Occurs more than 8 times a year

d. Does the Veteran have erythromelalgia?
☐ Yes ☐ No

NOTE: Characteristic attack of erythromelalgia consists of burning pain in the hands, feet or both, usually bilateral and symmetrical, with increased skin temperature and redness, occurring at warm ambient temperatures.

If yes, indicate severity and frequency of characteristic attacks:
   ☐ Do not restrict most routine daily activities
   ☐ Restrict most routine daily activities
   ☐ Occur less than 3 times a week
   ☐ Occur at least 3 times a week

   ☐ Occur daily
   ☐ Occur more than once a day

☐ Last an average of more than 2 hours each
☐ Respond to treatment
☐ Respond poorly to treatment

Section VII: Miscellaneous Issues

1. Amputations

Has the Veteran had an amputation of an extremity due to a vascular condition?
☐ Yes ☐ No
If yes, also complete Amputations Questionnaire

2. Assistive devices

a. Does the Veteran use any assistive device(s) as a normal mode of locomotion, although occasional locomotion by other methods may be possible?
☐ Yes ☐ No
If yes, identify assistive device(s) used (check all that apply and indicate frequency):

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant	
☐ Brace(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant	
☐ Crutch(es)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant	
☐ Cane(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant	
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant	
☐ Other: _____					_____
	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant	

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition: _____

3. Remaining effective function of the extremities

Due to a vascular condition, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)
☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.
☐ No
If yes, indicate extremity(ies) (check all extremities for which this applies)**:**
☐ Right upper ☐ Left upper ☐ Right lower ☐ Left lower
For each checked extremity, describe loss of effective function, identify the condition causing loss of function, and provide specific examples (brief summary): _____

4. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, are any of the scars painful and/or unstable, or is the total area of all related scars 39 square cm (6 square inches) or greater?
☐ Yes ☐ No
If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to the conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, describe (brief summary): _____

5. Diagnostic testing

a. Has ankle/brachial index testing been performed?
☐ Yes ☐ No ☐ Unable to perform, provide reason: _____
If yes, provide most recent results:

☐ Right ankle/brachial index: _____ Date: _____
☐ Left ankle/brachial index: _____ Date: _____

NOTE: An ankle/brachial index is required for peripheral vascular disease or aneurysm of any large artery (other than aorta), arteriosclerosis obliterans or thrombo-angiitis obliterans (Buerger's disease) if not of record, or if there has been an intervening change in the Veteran's peripheral vascular condition.

b. Are there any other significant diagnostic test findings and/or results?
☐ Yes ☐ No
If yes, provide type of test or procedure, date and results (brief summary): _____

6. Functional impact
Does the Veteran's vascular condition(s) impact his or her ability to work?
☐ Yes ☐ No
If yes, describe impact of each of the Veteran's vascular condition, providing one or more examples:
_____

7. Remarks, if any:
_____

Physician signature: _____ Date: _____
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.3. DBQ Elbow and Forearm Conditions

Name of patient/Veteran: _____SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever had an elbow or forearm condition?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to elbow and forearm conditions:
Diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

Diagnosis #2: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

Diagnosis #3: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

If there are additional diagnoses that pertain to elbow and forearm conditions, list using above format: _____

2. Medical history

a. Describe the history (including onset and course) of the Veteran's elbow and forearm condition (brief summary):
_____

b. Dominant hand:
☐ Right ☐ Left ☐ Ambidextrous

3. Flare-ups

Does the Veteran report that flare-ups impact the function of the elbow and/or forearm?
☐ Yes ☐ No
If yes, document the Veteran's description of the impact of flare-ups in his or her own words: _____

4. Initial range of motion (ROM) measurements

Measure ROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the measurements, document the point at which painful motion begins, evidenced by visible behavior such as facial expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use testing must be included in all joint exams. The VA has determined that 3 repetitions of ROM (at a minimum) can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM after 3 repetitions. Report post-test measurements in section 5.

a. Right elbow flexion

Select where flexion ends (normal endpoint is 145 degrees):

☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40
☐45 ☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85
☐90 ☐95 ☐100 ☐105 ☐110 ☐115 ☐120 ☐125 ☐130
☐135 ☐140 ☐145 or greater

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40
☐45 ☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85
☐90 ☐95 ☐100 ☐105 ☐110 ☐115 ☐120 ☐125 ☐130
☐135 ☐140 ☐145 or greater

b. Right elbow extension

Select where extension ends:

☐ 0 or any degree of hyperextension (no limitation of extension)
Unable to fully extend; extension ends at:
☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40
☐45 ☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85
☐90 ☐95 ☐100 ☐105 ☐110 or greater

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐ 0 or any degree of hyperextension (no limitation of extension)
Unable to fully extend; extension ends at:
☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40
☐45 ☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85
☐90 ☐95 ☐100 ☐105 ☐110 or greater

c. Left elbow flexion

Select where flexion ends (normal endpoint is 145 degrees):

☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40
☐45 ☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85
☐90 ☐95 ☐100 ☐105 ☐110 ☐115 ☐120 ☐125 ☐130
☐135 ☐140 ☐145 or greater

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40
☐45 ☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85
☐90 ☐95 ☐100 ☐105 ☐110 ☐115 ☐120 ☐125 ☐130
☐135 ☐140 ☐145 or greater

d. Left elbow extension

Select where extension ends:

☐ 0 or any degree of hyperextension (no limitation of extension)
Unable to fully extend; extension ends at:
☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40
☐45 ☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85
☐90 ☐95 ☐100 ☐105 ☐110 or greater

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐ 0 or any degree of hyperextension (no limitation of extension)
Unable to fully extend; extension ends at:

☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40
☐45 ☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85
☐90 ☐95 ☐100 ☐105 ☐110 or greater

e. If ROM does not conform to the normal range of motion identified above but is normal for this Veteran (for reasons other than an elbow condition, such as age, body habitus, neurologic disease), explain: _____

5. ROM measurements after repetitive use testing

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?
☐ Yes ☐ No If unable, provide reason: _____
If Veteran is unable to perform repetitive-use testing, skip to section 6.
If Veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions:

b. Right elbow post-test ROM

Select where post-test flexion ends:
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40
☐45 ☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85
☐90 ☐95 ☐100 ☐105 ☐110 ☐115 ☐120 ☐125 ☐130
☐135 ☐140 ☐145 or greater

Select where post-test extension ends:
☐ 0 or any degree of hyperextension (no limitation of extension)
Unable to fully extend; extension ends at:
☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40
☐45 ☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85
☐90 ☐95 ☐100 ☐105 ☐110 or greater

c. Left elbow post-test ROM

Select where post-test flexion ends:
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40
☐45 ☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85
☐90 ☐95 ☐100 ☐105 ☐110 ☐115 ☐120 ☐125 ☐130
☐135 ☐140 ☐145 or greater

Select where post-test extension ends:
☐ 0 or any degree of hyperextension (no limitation of extension)
Unable to fully extend; extension ends at:
☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50 ☐55 ☐60 ☐65 ☐70
☐75 ☐80 ☐85 ☐90 ☐95 ☐100 ☐105 ☐110 or greater

6. Functional loss and additional limitation in ROM

The following section addresses reasons for functional loss, if present, and additional loss of ROM after repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance.

a. Does the Veteran have additional limitation in ROM of the elbow and forearm following repetitive-use testing?
☐ Yes ☐ No

b. Does the Veteran have any functional loss and/or functional impairment of the elbow and forearm?
☐ Yes ☐ No

c. If the Veteran has functional loss, functional impairment and/or additional limitation of ROM of the elbow and forearm after repetitive use, indicate the contributing factors of disability below (check all that apply and indicate side affected):
☐ No functional loss for right upper extremity
☐ No functional loss for left upper extremity

☐ Less movement than normal ☐ Right ☐ Left ☐ Both
☐ More movement than normal ☐ Right ☐ Left ☐ Both
☐ Weakened movement ☐ Right ☐ Left ☐ Both
☐ Excess fatigability ☐ Right ☐ Left ☐ Both
☐ Incoordination, impaired ability to execute skilled movements smoothly ☐ Right ☐ Left ☐ Both
☐ Pain on movement ☐ Right ☐ Left ☐ Both
☐ Swelling ☐ Right ☐ Left ☐ Both
☐ Deformity ☐ Right ☐ Left ☐ Both
☐ Atrophy of disuse ☐ Right ☐ Left ☐ Both

7. Pain (pain on palpation)

Does the Veteran have localized tenderness or pain on palpation of joints/soft tissue of either elbow or forearm?

☐ Yes ☐ No

If yes, side affected: ☐ Right ☐ Left ☐ Both

8. Muscle strength testing

Rate strength according to the following scale:

0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance
5/5 Normal strength

Elbow flexion:	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Elbow extension:	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5

9. Ankylosis

Does the Veteran have ankylosis of the elbow?

☐ Yes ☐ No

If yes, indicate side and severity:

☐ At an angle of more than 90 degrees ☐ Right ☐ Left ☐ Both
☐ At an angle between 90 and 70 degrees ☐ Right ☐ Left ☐ Both
☐ At an angle between 70 and 50 degrees ☐ Right ☐ Left ☐ Both
☐ At an angle of less than 50 degrees ☐ Right ☐ Left ☐ Both

10. Additional conditions:

Does the Veteran have flail joint, joint fracture and/or impairment of supination or pronation?

☐ Yes ☐ No

If yes, indicate condition and complete the appropriate sections below.

a. ☐ Flail joint of the elbow
If checked, indicate side: ☐ Right ☐ Left ☐ Both

b. ☐ Intra-articular fracture (joint fracture) with marked varus or valgus deformity?
If checked, indicate side: ☐ Right ☐ Left ☐ Both

c. ☐ Intra-articular fracture (joint fracture) with ununited fracture of the head of the radius?
If checked, indicate side: ☐ Right ☐ Left ☐ Both

d. ☐ Impairment of supination or pronation
If checked, indicate severity and side

☐ Supination limited to 30 degrees or less	☐ Right	☐ Left	☐ Both
☐ Limited pronation with motion lost beyond the last quarter of the arc; hand does not approach full pronation	☐ Right	☐ Left	☐ Both
☐ Limited pronation with motion lost beyond the middle of the arc	☐ Right	☐ Left	☐ Both
☐ Hand is fixed near the middle of the arc or moderate pronation due to bone fusion	☐ Right	☐ Left	☐ Both
☐ Hand fixed in full pronation due to bone fusion	☐ Right	☐ Left	☐ Both
☐ Hand fixed in supination or hyperpronation due to bone fusion	☐ Right	☐ Left	☐ Both

11. Joint replacement and other surgical procedures

a. Has the Veteran had a total elbow joint replacement?
☐ Yes ☐ No
If yes, indicate side and severity of residuals.
☐ Right elbow
Date of surgery: _____
Residuals:
☐ None
☐ Intermediate degrees of residual weakness, pain and/or limitation of motion
☐ Chronic residuals consisting of severe painful motion and/or weakness
☐ Other, describe: _____
☐ Left elbow
Date of surgery: _____
Residuals:
☐ None
☐ Intermediate degrees of residual weakness, pain or limitation of motion
☐ Chronic residuals consisting of severe painful motion or weakness
☐ Other, describe: _____

b. Has the Veteran had arthroscopic or other elbow surgery?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both
Date and type of surgery: _____

c. Does the Veteran have any residual signs and/or symptoms due to arthroscopic or other elbow surgery?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both
If yes, describe residuals: _____

12. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
☐ Yes ☐ No
If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, describe (brief summary): _____

NOTE: In all forearm injuries, if there are impaired finger movements due to tendon, muscle or nerve injuries, also complete the appropriate disability Questionnaire(s), such as the Hand, Peripheral Nerve and/or Muscle

Injuries Questionnaire.

13. Remaining effective function of the extremities

Due to the service-connected disabling condition(s), is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)

☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.
☐ No

If yes, indicate extremities for which this applies**:**
☐ Right upper ☐ Left upper
For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary): _____

14. Diagnostic Testing

The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

a. Have imaging studies of the elbow been performed and are the results available?
☐ Yes ☐ No
If yes, is degenerative or traumatic arthritis documented?
☐ Yes ☐ No
If yes, indicate elbow: ☐ Right ☐ Left ☐ Both

b. Are there any other significant diagnostic test findings and/or results?
☐ Yes ☐ No
If yes, provide type of test or procedure, date and results (brief summary): _____

15. Functional impact

Does the Veteran's elbow/forearm condition impact his or her ability to work?

☐ Yes ☐ No

If yes describe the impact of each of the Veteran's conditions providing one or more examples_____

16. Remarks, if any: _____

Physician signature: _____ Date: ___
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.4. DBQ Flatfoot (Pes Planus)

Name of patient/Veteran: _____SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever had flatfoot (pes planus)?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to flatfoot:
Diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

Diagnosis #2: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

Diagnosis #3: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

If there are additional diagnoses that pertain to flatfoot, list using above format: _____

If the Veteran has additional foot conditions other than flatfoot, (such as extreme tenderness on the plantar surfaces of the feet indicating plantar fasciitis), complete the Foot Miscellaneous Questionnaire.

2. Medical history

Describe the history (including onset and course) of the Veteran's current flatfoot condition (i.e., when did flatfoot first become symptomatic?) (brief summary): _____

3. Signs and symptoms

Indicate all signs and symptoms that apply to the Veteran's flatfoot condition, regardless of whether similar signs and symptoms appear more than once in different sections.

a. Does the Veteran have pain on use of the feet?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both
If yes, is the pain accentuated on use?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both

b. Does the Veteran have pain on manipulation of the feet?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both
If yes, is the pain accentuated on manipulation?
☐ Yes ☐ No

If yes, indicate side affected: ☐ Right ☐ Left ☐ Both

c. Is there indication of swelling on use?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both

d. Does the Veteran have characteristic calluses (or any calluses caused by the flatfoot condition)?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both

e. Are the Veteran's symptoms relieved by arch supports (or built up shoes or orthotics)?
☐ Yes ☐ No
If no, indicate side that remains symptomatic despite arch supports or orthotics:
☐ Right ☐ Left ☐ Both

f. Does the Veteran have extreme tenderness of plantar surface of one or both feet?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both
Is the tenderness improved by orthopedic shoes or appliances?
☐ Yes ☐ No

4. Alignment and deformity

a. Does the Veteran have decreased longitudinal arch height on weight-bearing?
☐ Yes ☐ No
If yes, indicate side affected : ☐ Right ☐ Left ☐ Both

b. Is there objective evidence of marked deformity of the foot (pronation, abduction etc.)?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both

c. Is there marked pronation of the foot?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both
If yes, is the condition improved by orthopedic shoes or appliances?
☐ Yes ☐ No

d. Does the weight-bearing line fall over or medial to the great toe?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both

e. Is there a lower extremity deformity other than pes planus, causing alteration of the weight bearing line?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both
Describe lower extremity deformity other than pes planus causing alteration of the weight bearing line: _____

f. Does the Veteran have "inward" bowing of the Achilles' tendon (i.e., hind foot valgus, with lateral deviation of the heel)?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both

g. Does the Veteran have marked inward displacement and severe spasm of the Achilles tendon (rigid hindfoot) on manipulation?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both
Is the marked inward displacement and severe spasm of the Achilles tendon improved by orthopedic shoes or appliances?
☐ Yes ☐ No
If yes, indicate side improved by orthopedic shoes or appliances: ☐ Right ☐ Left ☐ Both

5. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
☐ Yes ☐ No
If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, describe (brief summary): _____

6. Assistive devices

a. Does the Veteran use any assistive devices (other than corrective shoes or orthotic inserts) as a normal mode of locomotion, although occasional locomotion by other methods may be possible?
☐ Yes ☐ No
If yes, identify assistive devices used (check all that apply and indicate frequency):

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Brace(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutch(es)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____				
	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition: _____

7. Remaining effective function of the extremities

Due to the Veteran's flatfoot condition, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)
☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.
☐ No
If yes, indicate extremities for which this applies:
☐ Right lower ☐ Left lower
Identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary): _____

8. Diagnostic Testing

NOTE: Plain or weight-bearing foot x-rays are not required to make the diagnosis of flatfoot. The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

a. Have imaging studies of the foot been performed and are the results available?
☐ Yes ☐ No
If yes, is degenerative or traumatic arthritis documented?
☐ Yes ☐ No
If yes, indicate foot: ☐ Right ☐ Left ☐ Both

b. Are there any other significant diagnostic test finding and/or results?
☐ Yes ☐ No
If yes, provide type of test or procedure, date and results (brief summary): _____

9. Functional impact

Does the Veteran's flatfoot condition impact his or her ability to work?

☐ Yes ☐ No

If yes describe the impact of each of the Veteran's flatfoot conditions providing one or more examples: ____

10. Remarks, if any: _____

Physician signature: _____ Date: ___
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.5. DBQ Foot Miscellaneous (Other than Flatfoot Pes Planus)

Name of patient/Veteran: _____SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever had a foot condition (other than flatfoot)?
☐ Yes ☐ No

If yes, indicate diagnosis/es: (check all that apply) and complete appropriate section(s).
Provide only diagnoses that pertain to foot conditions other than flatfoot:

☐ Morton's neuroma	ICD code: _____	Date of diagnosis: _____
☐ Metatarsalgia	ICD code: _____	Date of diagnosis: _____
☐ Hammer toes	ICD code: _____	Date of diagnosis: _____
☐ Hallux valgus	ICD code: _____	Date of diagnosis: _____
☐ Hallux rigidus	ICD code: _____	Date of diagnosis: _____
☐ Claw foot (pes cavus)	ICD code: _____	Date of diagnosis: _____
☐ Malunion/nonunion of tarsal/metatarsal bones	ICD code: _____	Date of diagnosis: _____
☐ Foot injuries (specify): _____	ICD code: _____	Date of diagnosis: _____
☐ Other foot conditions (specify): _____	ICD code: _____	Date of diagnosis: _____

NOTE: If the Veteran has flatfoot, also complete the Flatfoot Questionnaire.

2. Medical history

Describe the history (including onset and course) of the Veteran's current foot condition (brief summary):
_____

3. Morton's neuroma (Morton's disease) and metatarsalgia

a. Does the Veteran have Morton's neuroma?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both

b. Does the Veteran have metatarsalgia?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both

4. Hammer toe

Does the Veteran have hammer toes?
☐ Yes ☐ No
If yes, which toes are affected on each side?
Right: ☐ None ☐ Great toe ☐ Second toe ☐ Third toe ☐ Fourth toe ☐ Little toe
Left: ☐ None ☐ Great toe ☐ Second toe ☐ Third toe ☐ Fourth toe ☐ Little toe

5. Hallux valgus
Does the Veteran now have or has he/she ever had hallux valgus?
☐ Yes ☐ No
If yes, complete the following:

a. Does the Veteran have symptoms due to a hallux valgus condition?
☐ Yes ☐ No
If yes, indicate severity (check all that apply):
☐ Mild or moderate symptoms
Side affected: ☐ Right ☐ Left ☐ Both
☐ Severe symptoms, with function equivalent to amputation of great toe
Side affected: ☐ Right ☐ Left ☐ Both

b. Has the Veteran had surgery for hallux valgus?
☐ Yes ☐ No
If yes, indicate type of surgery and side affected:
☐ Resection of metatarsal head
Date of surgery: _____
Side affected: ☐ Right ☐ Left ☐ Both
☐ Metatarsal osteotomy/metatarsal head osteotomy (equivalent to metatarsal head resection)
Date of surgery: _____
Side affected: ☐ Right ☐ Left ☐ Both
☐ Other surgery for hallux valgus, describe: _____
Date of surgery: _____
Side affected: ☐ Right ☐ Left ☐ Both

6. Hallux rigidus
Does the Veteran have hallux rigidus?
☐ Yes ☐ No
If yes, does the Veteran have symptoms due to hallux rigidus?
☐ Yes ☐ No
If yes, indicate severity (check all that apply):
☐ Mild or moderate symptoms
Side affected: ☐ Right ☐ Left ☐ Both
☐ Severe symptoms, with function equivalent to amputation of great toe
Side affected: ☐ Right ☐ Left ☐ Both

7. Pes cavus (claw foot)
Does the Veteran have acquired claw foot (pes cavus)?
☐ Yes ☐ No
If yes, complete the following:

a. Effect on toes due to pes cavus (check all that apply)
☐ None ☐ Right ☐ Left ☐ Both
☐ Great toe dorsiflexed ☐ Right ☐ Left ☐ Both
☐ All toes tending to dorsiflexion ☐ Right ☐ Left ☐ Both
☐ All toes hammer toes ☐ Right ☐ Left ☐ Both
☐ Other, describe (if there is an effect on toes due to other etiology than pes cavus, indicate other etiology):
_____

b. Pain and tenderness due to pes cavus (check all that apply)

☐ None ☐ Right ☐ Left ☐ Both
☐ Definite tenderness under metatarsal heads ☐ Right ☐ Left ☐ Both
☐ Marked tenderness under metatarsal heads ☐ Right ☐ Left ☐ Both
☐ Very painful callosities ☐ Right ☐ Left ☐ Both
☐ Other, describe (if the Veteran has pain and tenderness due to other etiology than pes cavus, indicate other etiology): _____

c. Effect on plantar fascia due to pes cavus (check all that apply)

☐ None ☐ Right ☐ Left ☐ Both
☐ Shortened plantar fascia ☐ Right ☐ Left ☐ Both
☐ Marked contraction of plantar fascia with dropped forefoot ☐ Right ☐ Left ☐ Both
☐ Other, describe (if there is an effect on plantar fascia due to other etiology than pes cavus, indicate other etiology): _____

d. Dorsiflexion and varus deformity due to pes cavus (check all that apply)

☐ None ☐ Right ☐ Left ☐ Both
☐ Some limitation of dorsiflexion at ankle ☐ Right ☐ Left ☐ Both
☐ Limitation of dorsiflexion at ankle to right angle ☐ Right ☐ Left ☐ Both
☐ Marked varus deformity ☐ Right ☐ Left ☐ Both
☐ Other, describe (if the Veteran has dorsiflexion and varus deformity due to other etiology than pes cavus, indicate other etiology): _____

8. Malunion or nonunion of tarsal or metatarsal bones

Does the Veteran have malunion or nonunion of tarsal or metatarsal bones?
☐ Yes ☐ No

Indicate severity and side affected:

☐ Moderate ☐ Right ☐ Left ☐ Both
☐ Moderately severe ☐ Right ☐ Left ☐ Both
☐ Severe ☐ Right ☐ Left ☐ Both

9. Foot injuries

Does the Veteran have any other foot injuries?
☐ Yes ☐ No
If yes, describe: _____
If yes, indicate severity and side affected:

☐ Moderate ☐ Right ☐ Left ☐ Both
☐ Moderately severe ☐ Right ☐ Left ☐ Both
☐ Severe ☐ Right ☐ Left ☐ Both

10. Bilateral weak foot

NOTE: For VA purposes, bilateral weak foot is a symptomatic condition secondary to many constitutional conditions characterized by atrophy of the musculature, disturbed circulation and weakness.

Is there evidence of bilateral weak foot?
☐ Yes ☐ No
If yes, describe and report underlying condition: _____

11. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

☐ Yes ☐ No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

☐ Yes ☐ No

If yes, describe (brief summary): _____

12. Assistive devices

a. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible?

☐ Yes ☐ No

If yes, identify assistive devices used (check all that apply and indicate frequency):

☐ Wheelchair	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Brace(s)	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Crutch(es)	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition: _____

13. Remaining effective function of the extremities

Due to the Veteran's foot condition, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)

☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.

☐ No

If yes, indicate extremities for which this applies:

☐ Right lower ☐ Left lower

For each checked extremity, describe loss of effective function, identify the condition causing loss of function, and provide specific examples (brief summary): _____

14. Diagnostic Testing

The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

a. Have imaging studies of the foot been performed and are the results available?

☐ Yes ☐ No

If yes, are there abnormal findings?

☐ Yes ☐ No

If yes, indicate findings:

☐ Degenerative or traumatic arthritis

Foot: ☐ Right ☐ Left ☐ Both

Is degenerative or traumatic arthritis documented in multiple joints of the same foot, including thumb and fingers?

☐ Yes ☐ No
If yes, indicate hand: ☐ Right ☐ Left ☐ Both
☐ Other. Describe: _____
Foot: ☐ Right ☐ Left ☐ Both

b. Are there any other significant diagnostic test findings and/or results?
☐ Yes ☐ No
If yes, provide type of test or procedure, date and results (brief summary): _____

15. Functional impact
Does the Veteran's foot condition impact his or her ability to work?

☐ Yes ☐ No

If yes, describe the impact of each of the Veteran's foot conditions providing one or more examples: ___

16. Remarks, if any: _____

Physician signature: _____ Date: ___
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.6. DBQ Hand and Finger Conditions

Name of patient/Veteran: _____SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever had a hand or finger condition?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to hand conditions:
Diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

Diagnosis #2: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

Diagnosis #3: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

If there are additional diagnoses that pertain to hand conditions, list using above format: _____

2. Medical history

a. Describe the history (including onset and course) of the Veteran's hand condition (brief summary):
_____

b. Dominant hand:
☐ Right ☐ Left ☐ Ambidextrous

3. Flare-ups

Does the Veteran report that flare-ups impact the function of the hand?
☐ Yes ☐ No
If yes, document the Veteran's description of the impact of flare-ups in his or her own words: _____

4. Initial range of motion (ROM) measurements

Measure ROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the measurements, document the point at which painful motion begins, evidenced by visible behavior such as facial expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use testing must be included in all joint exams. The VA has determined that 3 repetitions of ROM (at a minimum) can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM after 3 repetitions. Report post-test measurements in section 5.

a. Is there limitation of motion or evidence of painful motion for any fingers or thumbs?
☐ Yes ☐ No
If no, skip to section 5
If yes, indicate digits affected (check all that apply):
Right: ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
Left: ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

b. Ability to oppose thumb: Is there a gap between the thumb pad and the fingers?
☐ Yes ☐ No
If yes, indicate distance of gap and side affected:
☐ Less than 1 inch (2.5 cm.) ☐ Right ☐ Left ☐ Both
☐ 1 to 2 inches (2.5 to 5.1 cm.) ☐ Right ☐ Left ☐ Both
☐ More than 2 inches (5.1 cm.) ☐ Right ☐ Left ☐ Both

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion
☐ Pain begins at gap of less than 1 inch (2.5 cm.) ☐ Right ☐ Left ☐ Both
☐ Pain begins at gap of 1 to 2 inches (2.5 to 5.1 cm.) ☐ Right ☐ Left ☐ Both
☐ Pain begins at gap of more than 2 inches (5.1 cm.) ☐ Right ☐ Left ☐ Both

c. Finger flexion: Is there a gap between any fingertips and the proximal transverse crease of the palm or evidence of painful motion in attempting to touch the palm with the fingertips?
☐ Yes ☐ No
If yes, indicate the gap:
☐ Gap less than 1 inch (2.5 cm)
Indicate fingers affected (check all that apply):
Right: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
Left: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

☐ Gap 1 inch (2.5 cm) or more
Indicate fingers affected (check all that apply):
Right: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
Left: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion
☐ Painful motion begins at a gap of less than 1 inch (2.5 cm)
Indicate fingers affected (check all that apply):
Right: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
Left: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

☐ Painful motion begins at a gap of 1 inch (2.5 cm) or more
Indicate fingers affected (check all that apply):
Right: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
Left: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

d. Finger extension: Is there limitation of extension or evidence of painful motion for the index finger or long finger?
☐ Yes ☐ No
If yes, indicate limitation of extension:
☐ Extension limited by no more than 30 degrees (unable to extend finger fully, extension limited to between 0 and 30 degrees of flexion)
Indicate fingers affected: (check all that apply)
Right: ☐ Index finger ☐ Long finger
Left: ☐ Index finger ☐ Long finger
☐ Extension limited by more than 30 degrees (unable to extend finger fully, extension limited to 31 degrees or more of flexion)
Indicate fingers affected: (check all that apply)
Right: ☐ Index finger ☐ Long finger
Left: ☐ Index finger ☐ Long finger

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion
☐ Painful motion begins at extension of no more than 30 degrees (unable to extend finger fully, painful extension begins between 0 and 30 degrees of flexion)
Indicate fingers affected: (check all that apply)
Right: ☐ Index finger ☐ Long finger
Left: ☐ Index finger ☐ Long finger
☐ Painful motion begins at extension of more than 30 degrees (unable to extend finger fully, painful extension begins at 31 degrees or more of flexion)
Indicate fingers affected: (check all that apply)
Right: ☐ Index finger ☐ Long finger
Left: ☐ Index finger ☐ Long finger

e. If ROM does not conform to the normal range of motion identified above but is normal for this Veteran (for reasons other than a hand condition, such as age, body habitus, neurologic disease), explain: _____

5. ROM measurements after repetitive use testing
a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?
☐ Yes ☐ No If unable, provide reason: _____
If Veteran is unable to perform repetitive-use testing, skip to section 6.
If Veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions:

b. Is there additional limitation of motion for any fingers post-test?
☐ Yes ☐ No
If yes, indicate digit(s) affected: (check all that apply)
Right: ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
Left: ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

c. Ability to oppose thumb: Is there a gap between the thumb pad and the fingers post-test?
☐ Yes ☐ No
If yes, indicate distance of gap and side affected:
☐ Less than 1 inch (2.5 cm.) ☐ Right ☐ Left ☐ Both
☐ 1 to 2 inches (2.5 to 5.1 cm.) ☐ Right ☐ Left ☐ Both
☐ More than 2 inches (5.1 cm.) ☐ Right ☐ Left ☐ Both

d. Finger flexion: Is there a gap between any fingertips and the proximal transverse crease of the palm in attempting to touch the palm with the fingertips post-test?

☐ Yes ☐ No

If yes, indicate the gap:

☐ Gap less than 1 inch (2.5 cm)

Indicate fingers affected (check all that apply):

Right: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

Left: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

☐ Gap 1 inch (2.5 cm) or more

Indicate fingers affected (check all that apply):

Right: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

Left: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

e. Finger extension: Is there limitation of extension for the index finger or long finger post-test?

☐ Yes ☐ No

If yes, indicate limitation of extension:

☐ Extension limited by no more than 30 degrees (unable to extend finger fully, extension limited to between 0 and 30 degrees of flexion)

Indicate fingers affected: (check all that apply)

Right: ☐ Index finger ☐ Long finger

Left: ☐ Index finger ☐ Long finger

☐ Extension limited by more than 30 degrees (unable to extend finger fully, extension limited to 31 degrees or more of flexion)

Indicate fingers affected: (check all that apply)

Right: ☐ Index finger ☐ Long finger

Left: ☐ Index finger ☐ Long finger

6. Functional loss and additional limitation of ROM

The following section addresses reasons for functional loss, if present, and additional loss of ROM after repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance.

a. Does the Veteran have any functional loss or functional impairment of any of the fingers or thumbs?

☐ Yes ☐ No

b. Does the Veteran have additional limitation in ROM of any of the fingers or thumbs following repetitive-use testing?

☐ Yes ☐ No

c. If the Veteran has functional loss, functional impairment or additional limitation of ROM of any of the fingers or thumbs after repetitive use, indicate the contributing factors of disability below (check all that apply; indicate digit and side affected):

☐ No functional loss for right hand, thumb or fingers

☐ No functional loss for left hand, thumb or fingers

☐ Less movement than normal

Right: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

Left: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

☐ More movement than normal

Right: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

Left: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

☐ Weakened movement

Right: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

Left: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

☐ Excess fatigability

Right: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
Left: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

☐ Incoordination, impaired ability to execute skilled movements smoothly
Right: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
Left: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

☐ Pain on movement
Right: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
Left: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

☐ Swelling
Right: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
Left: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

☐ Deformity
Right: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
Left: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

☐ Atrophy of disuse
Right: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
Left: ☐ All ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger

☐ Other, describe: _____

7. Pain (pain on palpation)

Does the Veteran have tenderness or pain to palpation for joints or soft tissue of either hand, including thumb and fingers

☐ Yes ☐ No

If yes, side affected: ☐ Right ☐ Left ☐ Both

8. Muscle strength testing

Rate strength according to the following scale:
0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance
5/5 Normal strength

Hand grip: Right: ☐ 5/5 ☐ 4/5 ☐ 3/5 ☐ 2/5 ☐ 1/5 ☐ 0/5
Left: ☐ 5/5 ☐ 4/5 ☐ 3/5 ☐ 2/5 ☐ 1/5 ☐ 0/5

9. Ankylosis

a. Does the Veteran have ankylosis of the thumb and/or fingers?

☐ Yes ☐ No

If yes, check all that apply:

Right thumb:

☐ Carpometacarpal joint ankylosis:
☐ In extension ☐ In full flexion ☐ In rotation or angulation
☐ Thumb is abducted and rotated so that the thumb pad faces the finger pads

☐ Interphalangeal joint ankylosis:
☐ In extension ☐ In full flexion ☐ In rotation or angulation
☐ Thumb is abducted and rotated so that the thumb pad faces the finger pads

☐ There is a gap of more than two inches (5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers.

☐ There is a gap of two inches (5.1 cm.) or less between the thumb pad and the fingers, with the thumb attempting to oppose the fingers.

Left thumb:
☐ Carpometacarpal joint ankylosis:
☐ In extension ☐ In full flexion ☐ In rotation or angulation
☐ Thumb is abducted and rotated so that the thumb pad faces the finger pads
☐ Interphalangeal joint ankylosis:
☐ In extension ☐ In full flexion ☐ In rotation or angulation
☐ Thumb is abducted and rotated so that the thumb pad faces the finger pads
☐ There is a gap of more than two inches (5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers.
☐ There is a gap of two inches (5.1 cm.) or less between the thumb pad and the fingers, with the thumb attempting to oppose the fingers.

Right: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
☐ Metacarpophalangeal joint ankylosis:
☐ In extension ☐ In full flexion ☐ In rotation or angulation
☐ Flexed to 30 degrees
☐ Proximal interphalangeal joint ankylosis:
☐ In extension ☐ In full flexion ☐ In rotation or angulation
☐ Flexed to 30 degrees
☐ There is a gap of more than two inches (5.1 cm.) between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible.
☐ There is a gap of two inches (5.1 cm.) or less between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible.

Left: ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Little finger
☐ Metacarpophalangeal joint ankylosis:
☐ In extension ☐ In full flexion ☐ In rotation or angulation
☐ Flexed to 30 degrees
☐ Proximal interphalangeal joint ankylosis:
☐ In extension ☐ In full flexion ☐ In rotation or angulation
☐ Flexed to 30 degrees
☐ There is a gap of more than two inches (5.1 cm.) between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible.
☐ There is a gap of two inches (5.1 cm.) or less between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible.

b. If there is ankylosis of more than one finger, provide details using above descriptions: _____

c. Does the ankylosis condition result in limitation of motion of other digits or interference with overall function of the hand?
☐ Yes ☐ No
If yes, describe: _____

10. Other pertinent physical findings, complications, conditions, signs and/or symptoms
a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
☐ Yes ☐ No
If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, describe (brief summary): _____

11. Assistive devices and remaining function of the extremities
a. Does the Veteran use any assistive devices?
☐ Yes ☐ No
If yes, identify assistive devices used (check all that apply and indicate frequency):
☐ Brace(s) Frequency of use: ☐ Occasional ☐ Regular ☐ Constant
☐ Other: _____ Frequency of use: ☐ Occasional ☐ Regular ☐ Constant
b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition: _____

12. Remaining effective function of the extremities
Due to the Veteran's hand, finger or thumb conditions, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)
☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.
☐ No
If yes, indicate extremities for which this applies**:**
☐ Right upper ☐ Left upper
For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary): _____

13. Diagnostic Testing
The diagnosis of arthritis must be confirmed by imaging studies. Once arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

a. Have imaging studies of the hands been performed and are the results available?
☐ Yes ☐ No

If yes, are there abnormal findings?
☐ Yes ☐ No
If yes, indicate findings:
☐ Degenerative or traumatic arthritis
Hand: ☐ Right ☐ Left ☐ Both
Is degenerative or traumatic arthritis documented in multiple joints of the same hand, including thumb and fingers?
☐ Yes ☐ No
If yes, indicate hand: ☐ Right ☐ Left ☐ Both
☐ Other. Describe: _____
Hand: ☐ Right ☐ Left ☐ Both

b. Are there any other significant diagnostic test findings and/or results?
☐ Yes ☐ No
If yes, provide type of test or procedure, date and results (brief summary): _____

14. Functional impact

Do the Veteran's hand, thumb, or finger conditions impact his or her ability to work?

☐ Yes ☐ No

If yes, describe the impact of each of the Veteran's hand, thumb and/or finger conditions, providing one or more examples: _____

15. Remarks, if any: _____

Physician signature: _____ Date: ___
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.7. DBQ Hip and Thigh Conditions

Name of patient/Veteran: _____SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever had a hip and/or thigh condition?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to hip/thigh conditions:
Diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

Diagnosis #2: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

Diagnosis #3: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

If there are additional diagnoses pertaining to hip/thigh conditions, list using above format: _____

2. Medical history

Describe the history (including onset and course) of the Veteran's current hip/thigh condition(s) (brief summary):_____

3. Flare-ups

Does the Veteran report that flare-ups impact the function of the hip and/or thigh?
☐ Yes ☐ No
If yes, document the Veteran's description of the impact of flare-ups in his or her own words: _____

4. Initial range of motion (ROM) measurements

Measure ROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the measurements, document the point at which painful motion begins, evidenced by visible behavior such as facial expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use testing must be included in all joint exams. The VA has determined that 3 repetitions of ROM (at a minimum) can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM after 3 repetitions. Report post-test measurements in section 5.

a. Right hip flexion
Select where flexion ends (normal endpoint is 125 degrees):
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45

☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85 ☐90 ☐ 95
☐100 ☐105 ☐110 ☐115 ☐120 ☐125 or greater

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45
☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85 ☐90 ☐ 95
☐100 ☐105 ☐110 ☐115 ☐120 ☐125 or greater

b. Right hip extension
Select where extension ends:
☐ 0 ☐ 5 ☐ Greater than 5

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion
☐ 0 ☐ 5 ☐ Greater than 5

Is abduction lost beyond 10 degrees?
☐ Yes ☐ No

Is adduction limited such that the Veteran cannot cross legs?
☐ Yes ☐ No

Is rotation limited such that the Veteran cannot toe-out more than 15 degrees?
☐ Yes ☐ No

c. Left hip flexion
Select where flexion ends (normal endpoint is 125 degrees):
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45
☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85 ☐90 ☐ 95
☐100 ☐105 ☐110 ☐115 ☐120 ☐125 or greater

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45
☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85 ☐90 ☐ 95
☐100 ☐105 ☐110 ☐115 ☐120 ☐125 or greater

d. Left hip extension
Select where extension ends:
☐ 0 ☐ 5 ☐ Greater than 5

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion
☐ 0 ☐ 5 ☐ Greater than 5

Is abduction lost beyond 10 degrees?
☐ Yes ☐ No

Is adduction limited such that the Veteran cannot cross legs?
☐ Yes ☐ No

Is rotation limited such that the Veteran cannot toe-out more than 15 degrees?
☐ Yes ☐ No

e. If ROM does not conform to the normal range of motion identified above but is normal for this Veteran (for

reasons other than a hip condition, such as age, body habitus, neurologic disease), explain: _____

5. ROM measurements after repetitive use testing

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?
☐ Yes ☐ No If unable, provide reason: _____
If Veteran is unable to perform repetitive-use testing, skip to section 6.
If Veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions.

b. Right hip post-test ROM

Select where post-test flexion ends:
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45
☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85 ☐90 ☐ 95
☐100 ☐105 ☐110 ☐115 ☐120 ☐125 or greater

Select where post-test extension ends:
☐ 0 ☐ 5 or greater

Is post-test abduction lost beyond 10 degrees?
☐ Yes ☐ No

Is post-test adduction limited such that the Veteran cannot cross legs?
☐ Yes ☐ No

Is post-test rotation limited such that the Veteran cannot toe-out more than 15 degrees?
☐ Yes ☐ No

c. Left hip post-test ROM

Select where post-test flexion ends:
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45
☐50 ☐55 ☐60 ☐65 ☐70 ☐75 ☐80 ☐85 ☐90 ☐ 95
☐100 ☐105 ☐110 ☐115 ☐120 ☐125 or greater

Select where post-test extension ends:
☐ 0 ☐ 5 or greater

Is post-test abduction lost beyond 10 degrees?
☐ Yes ☐ No

Is post-test adduction limited such that the Veteran cannot cross legs?
☐ Yes ☐ No

Is post-test rotation limited such that the Veteran cannot toe-out more than 15 degrees?
☐ Yes ☐ No

6. Functional loss and additional limitation in ROM

The following section addresses reasons for functional loss, if present, and additional loss of ROM after repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance.

a. Does the Veteran have additional limitation in ROM of the hip and thigh following repetitive-use testing?
☐ Yes ☐ No

b. Does the Veteran have any functional loss and/or functional impairment of the hip and thigh?
☐ Yes ☐ No

c. If the Veteran has functional loss, functional impairment and/or additional limitation of ROM of the hip and

thigh after repetitive use, indicate the contributing factors of disability below (check all that apply and indicate side affected):

☐ No functional loss for right lower extremity
☐ No functional loss for left lower extremity
☐ Less movement than normal ☐ Right ☐ Left ☐ Both
☐ More movement than normal ☐ Right ☐ Left ☐ Both
☐ Weakened movement ☐ Right ☐ Left ☐ Both
☐ Excess fatigability ☐ Right ☐ Left ☐ Both
☐ Incoordination, impaired ability to execute skilled movements smoothly ☐ Right ☐ Left ☐ Both
☐ Pain on movement ☐ Right ☐ Left ☐ Both
☐ Swelling ☐ Right ☐ Left ☐ Both
☐ Deformity ☐ Right ☐ Left ☐ Both
☐ Atrophy of disuse ☐ Right ☐ Left ☐ Both
☐ Instability of station ☐ Right ☐ Left ☐ Both
☐ Disturbance of locomotion ☐ Right ☐ Left ☐ Both
☐ Interference with sitting, standing and or weight-bearing ☐ Right ☐ Left ☐ Both

7. Pain (pain on palpation)

Does the Veteran have localized tenderness or pain to palpation for joints/soft tissue of either hip?
☐ Yes ☐ No
If yes, side affected: ☐ Right ☐ Left ☐ Both

8. Muscle strength testing

Rate strength according to the following scale:
0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance
5/5 Normal strength

Hip flexion:	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Hip abduction:	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Hip extension:	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5

9. Ankylosis

Does the Veteran have ankylosis of either hip joint?
☐ Yes ☐ No
If yes, indicate severity and side affected:
☐ Favorable, in flexion at an angle between 20 and 40 degrees, and slight adduction or abduction
☐ Right ☐ Left ☐ Both
☐ Intermediate, between favorable and unfavorable
☐ Right ☐ Left ☐ Both
☐ Unfavorable, extremely unfavorable ankylosis, foot not reaching ground, crutches needed
☐ Right ☐ Left ☐ Both

10. Additional conditions

Does the Veteran have malunion or nonunion of femur, flail hip joint or leg length discrepancy?
☐ Yes ☐ No
If yes, indicate condition and complete the appropriate sections below.

a. ☐ Malunion or nonunion of the femur
If checked, indicate severity and side affected:

☐ Malunion with slight hip disability	☐ Right	☐ Left	☐ Both
☐ Malunion with moderate hip disability	☐ Right	☐ Left	☐ Both
☐ Malunion with marked hip disability	☐ Right	☐ Left	☐ Both
☐ Fracture of surgical neck with false joint	☐ Right	☐ Left	☐ Both
☐ Fracture of shaft or neck (anatomical), resulting in nonunion without loose motion; weight-bearing preserved with aid of a brace	☐ Right	☐ Left	☐ Both
☐ Fracture of shaft or neck (anatomical), with nonunion with loose motion (spiral or oblique fracture)	☐ Right	☐ Left	☐ Both

NOTE: If impairment of the femur causes any knee disability, also complete the Knee and Lower Leg Questionnaire.

b. ☐ Flail hip joint
If checked, indicate hip affected: ☐ Right ☐ Left ☐ Both

c. ☐ Leg length discrepancy (shortening of any bones of the lower extremity)
If checked, provide length of each lower extremity in inches (to the nearest 1/4 inch) or centimeters, measuring from the anterior superior iliac spine to the internal malleolus of the tibia.
Measurements: Right leg: _____ ☐ cm ☐ inches
Left leg: _____ ☐ cm ☐ inches

11. Joint replacement and other surgical procedures
a. Has the Veteran had a total hip joint replacement?
☐ Yes ☐ No
If yes, indicate side and severity of residuals.
☐ Right hip
Date of surgery: _____
Residuals:
☐ None
☐ Intermediate degrees of residual weakness, pain and/or limitation of motion
☐ Chronic residuals consisting of severe painful motion and/or weakness
☐ Other, describe: _____
☐ Left hip
Date of surgery: _____
Residuals:
☐ None
☐ Intermediate degrees of residual weakness, pain or limitation of motion
☐ Chronic residuals consisting of severe painful motion or weakness
☐ Other, describe: _____

b. Has the Veteran had arthroscopic or other hip surgery?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both
Date and type of surgery: _____

c. Does the Veteran have any residual signs and/or symptoms due to arthroscopic or other hip surgery?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both
If yes, describe residuals: _____

12. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
☐ Yes ☐ No
If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, describe (brief summary): _____

13. Assistive devices

a. Does the Veteran use any assistive device(s) as a normal mode of locomotion, although occasional locomotion by other methods may be possible?
☐ Yes ☐ No
If yes, identify assistive device(s) used (check all that apply and indicate frequency):

☐ Wheelchair	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Brace(s)	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Crutch(es)	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition: _____

14. Remaining effective function of the extremities

Due to the Veteran's hip and/or thigh condition(s), is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)
☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.
☐ No
If yes, indicate extremities for which this applies**:**
☐ Right lower ☐ Left lower
For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary): _____

15. Diagnostic Testing

The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, no further imaging studies are indicated, even if arthritis has worsened.

a. Have imaging studies of the hip been performed and are the results available?
☐ Yes ☐ No
If yes, is degenerative or traumatic arthritis documented?
☐ Yes ☐ No
If yes, indicate hip: ☐ Right ☐ Left ☐ Both

b. Are there any other significant diagnostic test findings and/or results?
☐ Yes ☐ No
If yes, provide type of test or procedure, date and results (brief summary): _____

16. Functional impact

Does the Veteran's hip and/or thigh condition impact his or her ability to work?

☐ Yes ☐ No

If yes, describe the impact of each of the Veteran's hip and/or thigh conditions providing one or more examples:
_____

17. Remarks, if any: _____

Physician signature: _____ Date: ___
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.8. DBQ Muscle Injuries

Name of patient/Veteran: _____SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

SECTION I: DIAGNOSIS

Does the Veteran now have or has he/she ever been diagnosed with a muscle injury?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to muscle injury(ies):

Diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

Diagnosis #2: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

Diagnosis #3: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

If there are additional diagnoses pertaining to muscle injuries, list using above format: _____

NOTE: If there are multiple muscle injuries, complete the assessment for all muscle injuries on this Questionnaire, if possible. If unable to complete assessment for all muscle injuries on this Questionnaire, also complete an additional Questionnaire for each additional injury.

If the Veteran has or has had a muscle injury that results in any conditions that are not covered in this Questionnaire, also complete any other appropriate Questionnaires (e.g., if peripheral nerve injury also exists due to the muscle injury, complete the Peripheral Nerves Questionnaire).

SECTION II: HISTORY OF MUSCLE INJURY

a. Does the Veteran have a penetrating muscle injury, such as a gunshot or shell fragment wound?
☐ Yes ☐ No

b. Does the Veteran have a non-penetrating muscle injury (such as a muscle strain, torn Achilles tendon or torn quadriceps muscle)?
☐ Yes ☐ No

c. Describe the history (including onset and course) of the Veteran's muscle injury: (brief summary): _____

d. Dominant hand
☐ Right ☐ Left ☐Ambidextrous

SECTION III: LOCATION OF MUSCLE INJURY

NOTE: For VA purposes, muscles are classified into groups I-XXIII. In this section, indicate the location of the Veteran's muscle injuries by checking the muscle groups involved.

1. Shoulder girdle and arm

Does the Veteran now have or has he/she ever had an injury to a muscle group of the shoulder girdle or arm?
☐ Yes ☐ No
If yes, check muscle group(s) and side affected (check all that apply):

☐ **Group I**: Extrinsic muscles of shoulder girdle: trapezius, levator scapulae, serratus magnus
Function: Upward rotation of scapula, elevation of arm above shoulder level
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group II:** Muscles of shoulder girdle: pectoralis major, latissimus dorsi and teres major, pectoralis minor, rhomboid
Function: Depression of arm from vertical overhead to hanging at side, downward rotation of scapula, forward and backward swing of arm
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group III:** Intrinsic muscles of shoulder girdle: pectoralis major, deltoid
Function: Elevation and abduction of arm to level of shoulder, forward and backward swing of arm.
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group IV:** Shoulder girdle muscles: supraspinatus, infraspinatus and teres minor, subscapularis, coracobrachialis
Function: Stabilization of shoulder, abduction, rotation of arm
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group V:** Flexor muscles of elbow: biceps, brachialis, brachioradialis
Function: Flexion of elbow
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group VI:** Extensor muscles of elbow: triceps
Function: Extension of elbow
Side affected: ☐ Right ☐ Left ☐ Both

2. Forearm and hand

Does the Veteran now have or has he/she ever had an injury to a muscle group of the forearm or hand?
☐ Yes ☐ No
If yes, check muscle group(s) and side affected (check all that apply):

☐ **Group VII:** Muscles of forearm: Flexors of the wrist, fingers and thumb
Function: Flexion of wrist and fingers
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group VIII:** Muscles: Extensors of the wrist, fingers and thumb
Function: Extension of wrist, fingers and thumb
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group IX:** Intrinsic muscles of hand, including muscles in the thenar and hypothenar eminence, lumbricales, dorsal and palmar interossei
Function: Intrinsic muscles of the hand assist in delicate manipulative movements
Side affected: ☐ Right ☐ Left ☐ Both

3. Foot and leg
Does the Veteran now have or has he/she ever had an injury to a muscle group of the foot or leg?
☐ Yes ☐ No
If yes, check muscle group(s) and side affected (check all that apply):

☐ **Group X:** Muscles of the foot: flexor digitorum brevis, abductor hallucis, abductor digiti minimi, quadratus plantae, lumbricales, flexor hallucis brevis, adductor hallucis, flexor digiti minimi brevis, dorsal and plantar interossei
Function: Movements of forefoot and toes, propulsion thrust in walking
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group XI:** Muscles of the foot, ankle and calf: gastrocnemius, soleus, tibalis posterior, peroneus longus, peroneus brevis, flexor hallucis longus, flexor digitorum longus
Function: Propulsion, plantar flexion of foot, stabilization of arch, flexion of toes
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group XII:** Anterior muscles of the leg: tibalis anterior, extensor digitorum longus, extensor hallucis longus, peroneus tertius
Function: Dorsiflexion, extension of toes, stabilization of arch
Side affected: ☐ Right ☐ Left ☐ Both

4. Pelvic girdle and thigh
Does the Veteran now have or has he/she ever had an injury to a muscle group of the pelvic girdle or thigh?
☐ Yes ☐ No
If yes, check muscle group(s) and side affected (check all that apply):

☐ **Group XIII:** Posterior thigh/hamstring muscles: biceps femoris, semimembranosus, semitendinosus
Function: Flexion of knee
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group XIV:** Anterior thigh muscles: sartorius, rectus femoris, quadriceps
Function: Extension of knee
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group XV:** Medial thigh muscles: adductor longus, adductor brevis, adductor magnus, gracilis
Function: Adduction of hip
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group XVI:** Pelvic girdle muscles: psoas, iliacus, pectineus
Function: Flexion of hip
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group XVII:** Pelvic girdle muscles: gluteus maximus, gluteus medius, gluteus minimus
Function: Extension of hip, abduction of thigh, postural support of body
Side affected: ☐ Right ☐ Left ☐ Both

If checked, is there severe damage to muscle group XVII, such that Veteran is unable to rise from a seated and stooped position and to maintain postural stability without assistance of any type?
☐ Yes ☐ No

☐ **Group XVIII:** Pelvic girdle muscles: pyriformis, gemelli, obturator, quadratus femoris
Function: Outward rotation of thigh and stabilization of hip joint
Side affected: ☐ Right ☐ Left ☐ Both

5. Torso and neck
Does the Veteran now have or has he/she ever had an injury to a muscle group in the torso and/or neck?

☐ Yes ☐ No
If yes, check muscle group(s) and side or region affected (check all that apply):

☐ **Group XIX:** Muscles of the abdominal wall: rectus abdominis, external oblique, internal oblique, transversalis, quadratus lumborum
Function: Support of abdominal wall and lower thorax, flexion and lateral movement of spine
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group XX:** Spinal muscles: sacrospinalis, erector spinae
Function: Postural support of body, extension and lateral movement of the spine
Region affected: ☐ Cervical ☐ Thoracic ☐ Lumbar

☐ **Group XXI:** Muscles of respiration: thoracic muscle group.
Function: Respiration
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group XXII:** Muscles of the front of the neck: trapezius, sternocleidomastoid, hyoid muscles, sternothyroid, digastric
Function: Rotation and flexion of the head, respiration, swallowing
Side affected: ☐ Right ☐ Left ☐ Both

☐ **Group XXIII:** Muscles of the side and back of the neck: suboccipital, lateral vertebral and anterior vertebral muscles
Function: Movements of the head, fixation of shoulder movements
Side affected: ☐ Right ☐ Left ☐ Both

6. Additional conditions
a. Does the Veteran have a history of rupture of the diaphragm with herniation?
☐ Yes ☐ No
If yes, also complete Hiatal Hernia Questionnaire.

b. Does the Veteran have a history of an extensive muscle hernia of any muscle, without other injury to the muscle? ☐ Yes ☐ No
If yes, name muscle and describe current residuals _____.

c. Does the Veteran have a history of injury to the facial muscles?
☐ Yes ☐ No
If yes, complete the Questionnaire for Cranial Nerves, Scars, etc., as indicated by type of residuals.
If yes, is there interference to any extent with mastication?
☐ Yes ☐ No

SECTION IV: MUSCLE INJURY EXAM
1. Scar, fascia and muscle findings
a. Does the Veteran have any scar(s) associated with a muscle injury?
☐ Yes ☐ No
If yes, indicate severity of scar(s) caused by the muscle injury(ies) (check all that apply if there is more than one area or type of scarring):
☐ Minimal scar(s)
☐ Entrance and (if present) exit scars are small or linear, indicating short track of missile through muscle tissue
☐ Entrance and (if present) exit scars indicating track of missile through one or more muscle groups
☐ Ragged, depressed and adherent scars indicating wide damage to muscle groups in missile track
☐ Adhesion of scar to one of the long bones, scapula, pelvic bones, sacrum or vertebrae, with epithelial sealing over the bone rather than true skin covering in an area where bone is normally protected by muscle
☐ Other (including surgical scars related to muscle injuries shown above), also complete Scars

Questionnaire

b. Does the Veteran have any known fascial defects or evidence of fascial defects associated with any muscle injuries?
☐ Yes ☐ No
If yes, indicate severity of fascial defect(s) caused by the muscle injury(ies) (check all that apply if there is more than one area/type of fascial defect):
☐ Some loss of deep fascial
☐ Palpation shows loss of deep fascia
☐ Other, describe: _____

c. Does the Veteran's muscle injury(ies) affect muscle substance or function?
☐ Yes ☐ No
If yes, indicate effect of the muscle injury(ies) on muscle substance or function (check all that apply):
☐ Some impairment of muscle tonus
☐ Some loss of muscle substance
☐ Soft flabby muscles in wound area
☐ Muscles swell and harden abnormally in contraction
☐ Induration or atrophy of an entire muscle following history of simple piercing by a projectile
☐ Adaptive contraction of an opposing group of muscles
☐ Visible or measurable atrophy
☐ Atrophy of muscle groups not in the track of the missile, particularly of the trapezius and serratus in wounds of the shoulder girdle
☐ Tests of endurance or coordinated movements compared with the corresponding muscles of the uninjured side indicate severe impairment of function
☐ Other, describe: _____

2. Cardinal signs and symptoms of muscle disability
Does the Veteran have any of the following signs and/or symptoms attributable to any muscle injuries?
☐ Yes ☐ No
If yes, check all that apply, and indicate side affected, muscle group and frequency/severity.
☐ Loss of power
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both
Indicate muscle group(s) affected (I-XXIII) if possible: _____
Indicate frequency/severity: ☐ Occasional ☐ Consistent ☐ Consistent at a more severe level
☐ Weakness
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both
Indicate muscle group(s) affected (I-XXIII) if possible: _____
Indicate frequency/severity: ☐ Occasional ☐ Consistent ☐ Consistent at a more severe level
☐ Lowered threshold of fatigue
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both
Indicate muscle group(s) affected (I-XXIII) if possible: _____
Indicate frequency/severity: ☐ Occasional ☐ Consistent ☐ Consistent at a more severe level
☐ Fatigue-pain
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both
Indicate muscle group(s) affected (I-XXIII) if possible: _____
Indicate frequency/severity: ☐ Occasional ☐ Consistent ☐ Consistent at a more severe level
☐ Impairment of coordination
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both
Indicate muscle group(s) affected (I-XXIII) if possible: _____
Indicate frequency/severity: ☐ Occasional ☐ Consistent ☐ Consistent at a more severe level
☐ Uncertainty of movement
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both
Indicate muscle group(s) affected (I-XXIII) if possible: _____
Indicate frequency/severity: ☐ Occasional ☐ Consistent ☐ Consistent at a more severe level
☐

If further clarification is needed due to injuries of multiple muscle groups, describe which findings, signs and/or symptoms are attributable to each muscle injury: _____

3. Muscle strength testing

Test muscle strength ONLY for affected muscle groups and for the corresponding sound (non-injured) side.

Rate strength according to the following scale:

0/5 No muscle movement
1/5 Visible muscle movement, but no joint movement
2/5 No movement against gravity
3/5 No movement against resistance
4/5 Less than normal strength
5/5 Normal strength

Shoulder abduction	(Group III)	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
		Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Elbow flexion	(Group V)	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
		Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Elbow extension	(Group VI)	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
		Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Wrist flexion	(Group VII)	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
		Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Wrist extension	(Group VIII)	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
		Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Hip flexion	(Group XVI)	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
		Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Knee flexion	(Group XIII)	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
		Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Knee extension	(Group XIV)	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
		Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Ankle plantar flexion	(Group XI)	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
		Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Ankle dorsiflexion	(Group XII)	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
		Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5

If other movements/muscle groups were tested, specify: _____

Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5

Does the Veteran have muscle atrophy?

☐ Yes ☐ No

If muscle atrophy is present, indicate location (such as calf, thigh, forearm, upper arm): _____

Indicate side affected: ☐ Right ☐ Left ☐ Both

Indicate muscle group(s) affected (I-XXIII) if possible: _____

Provide measurements in centimeters of normal side and atrophied side, measured at maximum muscle bulk:

Normal side: _____ cm. Atrophied side: _____ cm.

If muscle atrophy is present in more than one muscle group, provide location and measurements, using the same format: _____

SECTION V: OTHER

1. Assistive devices

a. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible?

☐ Yes ☐ No

If yes, identify assistive devices used (check all that apply and indicate frequency):

☐ Wheelchair Frequency of use: ☐ Occasional ☐ Regular ☐ Constant
☐ Brace(s) Frequency of use: ☐ Occasional ☐ Regular ☐ Constant
☐ Crutch(es) Frequency of use: ☐ Occasional ☐ Regular ☐ Constant
☐ Cane(s) Frequency of use: ☐ Occasional ☐ Regular ☐ Constant
☐ Walker Frequency of use: ☐ Occasional ☐ Regular ☐ Constant
☐ Other: _____
Frequency of use: ☐ Occasional ☐ Regular ☐ Constant

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition: _____

2. Remaining effective function of the extremities

Due to the Veteran's muscle conditions, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)

☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.
☐ No

If yes, indicate extremities for which this applies:

☐ Right lower ☐ Right upper ☐ Left lower ☐ Left upper

For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary): _____

3. Other pertinent physical findings, complications, conditions, signs and/or symptoms

Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms?

☐ Yes ☐ No

If yes, describe (brief summary): _____

4. Diagnostic Testing

NOTE: If there is reason to believe there are retained metallic fragments in the muscle tissue, appropriate x-rays are required to determine location of retained metallic fragments. Once retained metallic fragments have been documented, further imaging studies are usually not indicated.

a. Have imaging studies been performed and are the results available?

☐ Yes ☐ No

b. Is there x-ray evidence of retained metallic fragments (such as shell fragments or shrapnel) in any muscle group?

☐ Yes ☐ No

If yes, indicate results:

☐ X-ray evidence of retained shell fragment(s) and/or shrapnel
Location (specify muscle group I-XXIII, if possible): _____
Side affected: ☐ Right ☐ Left ☐ Both

☐ X-ray evidence of minute multiple scattered foreign bodies indicating intermuscular trauma and explosive effect of the missile
Location (specify muscle group I-XXIII, if possible): _____
Side affected: ☐ Right ☐ Left ☐ Both

c. Were electrodiagnostic tests done?

☐ Yes ☐ No

If yes, was there diminished muscle excitability to pulsed electrical current?

☐ Yes ☐ No

If yes, name affected muscle(s) _____.

d. Are there any other significant diagnostic test findings and/or results?
☐ Yes ☐ No
If yes, provide type of test or procedure, date and results (brief summary): _____

5. Functional impact

Does the Veteran's muscle injury(ies) impact his or her ability to work, such as resulting in inability to keep up with work requirements due to muscle injury(ies)?

☐ Yes ☐ No

If yes, describe the impact of each of the Veteran's muscle injuries providing one or more examples: _____

6. Remarks, if any: _____

Physician signature: _____ Date: _____
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.9. DBQ Temporomandibular Joint (TMJ) Conditions

Name of patient/Veteran: _____SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever had a temporomandibular joint condition?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to temporomandibular joint conditions:
Diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____

Diagnosis #2: _____
ICD code: _____
Date of diagnosis: _____

Diagnosis #3: _____
ICD code: _____
Date of diagnosis: _____

If there are additional diagnoses that pertain to temporomandibular joint conditions, list using above format.

2. Medical History

a. Describe the history (including onset and course) of the Veteran's temporomandibular joint condition (brief summary): _____

3. Flare-ups

Does the Veteran report that flare-ups impact the function of the temporomandibular joint?
☐ Yes ☐ No
If yes, document the Veteran's description of the impact of flare-ups on function in his or her own words: ____

4. Initial range of motion (ROM) measurements

Measure ROM. During the measurements, document the point at which painful motion begins, evidenced by visible behavior such as facial expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use testing must be included in all joint exams. The VA has determined that 3 repetitions of ROM (at a minimum) can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM after 3 repetitions. Report post-test measurements in section 5.

a. ROM for lateral excursion
- ☐ Greater than 4 mm
- ☐ 0 to 4 mm

Select where objective evidence of painful motion begins:
- ☐ No objective evidence of painful motion
- ☐ Greater than 4 mm
- ☐ 0 to 4 mm

b. ROM for opening mouth, measured by inter-incisal distance

- ☐ Greater than 40 mm
- ☐ 31 to 40 mm
- ☐ 21 to 30 mm
- ☐ 11 to 20 mm
- ☐ 0 to 10 mm

Select where objective evidence of painful motion begins:

- ☐ No objective evidence of painful motion
- ☐ Greater than 40 mm
- ☐ 31 to 40 mm
- ☐ 21 to 30 mm
- ☐ 11 to 20 mm
- ☐ 0 to 10 mm

c. If ROM does not conform to the normal range of motion identified above but is normal for this Veteran (for reasons other than a temporomandibular joint condition, such as age, body habitus, neurologic disease), explain: _____

5. ROM measurement after repetitive use testing

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?
☐ Yes ☐ No If unable, provide reason: _____
If Veteran is unable to perform repetitive-use testing, skip to section 6.
If Veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions.

b. Post-test ROM for lateral excursion

- ☐ 0 to 4 mm
- ☐ Greater than 4 mm

c. Post-test ROM for opening mouth, measured by Inter-incisal distance

- ☐ Greater than 40 mm
- ☐ 31 to 40 mm
- ☐ 21 to 30 mm
- ☐ 11 to 20 mm
- ☐ 0 to 10 mm

6. Functional loss and additional limitation in ROM

The following section addresses reasons for functional loss, if present, and additional loss of ROM after repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance.

a. Does the Veteran have additional limitation in ROM of either TMJ following repetitive-use testing?
☐ Yes ☐ No

b. Does the Veteran have any functional loss or functional impairment of either TMJ?
☐ Yes ☐ No

c. If the Veteran has functional loss, functional impairment and/or additional limitation of ROM of either TMJ after repetitive use, indicate the contributing factors of disability below (check all that apply and indicate side affected):

☐ No functional loss for right TMJ
☐ No functional loss for left TMJ
☐ Less movement than normal ☐ Right ☐ Left ☐ Both
☐ More movement than normal ☐ Right ☐ Left ☐ Both
☐ Weakened movement ☐ Right ☐ Left ☐ Both
☐ Excess fatigability ☐ Right ☐ Left ☐ Both
☐ Incoordination, impaired ability to execute skilled movements smoothly ☐ Right ☐ Left ☐ Both
☐ Pain on movement ☐ Right ☐ Left ☐ Both
☐ Swelling ☐ Right ☐ Left ☐ Both
☐ Deformity ☐ Right ☐ Left ☐ Both

7. Pain (pain on palpation) and crepitus

a. Does the Veteran have localized tenderness or pain on palpation of joints or soft tissues of either TMJ?
☐ Yes ☐ No
If yes, side affected: ☐ Right ☐ Left ☐ Both

b. Does the Veteran have clicking or crepitation of joints or soft tissues of either TMJ?
☐ Yes ☐ No
If yes, side affected: ☐ Right ☐ Left ☐ Both

8. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
☐ Yes ☐ No
If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, describe (brief summary): _____

9. Diagnostic testing

The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

a. Have imaging studies of the TMJ been performed and are the results available?
☐ Yes ☐ No

If yes, is degenerative or traumatic arthritis documented?
☐ Yes ☐ No
If yes, side affected: ☐ Right ☐ Left ☐ Both

b. Are there any other significant diagnostic test findings and/or results?
☐ Yes ☐ No
If yes, side affected: ☐ Right ☐ Left ☐ Both
If yes, provide type of test or procedure, date and results (brief summary): _____

10. Functional impact
Does the Veteran's temporomandibular joint condition impact his or her ability to work?
☐ Yes ☐ No
If yes, describe the impact of each of the Veteran's temporomandibular conditions, providing one or more examples: _____

11. Remarks, if any: _____

Physician signature: _____ Date: _____
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.10. DBQ Wrist Conditions

Name of patient/Veteran: _____SSN:_____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever had a wrist condition?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to wrist conditions:
Diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

Diagnosis #2: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

Diagnosis #3: _____
ICD code: _____
Date of diagnosis: _____
Side affected: ☐ Right ☐ Left ☐ Both

If there are additional diagnoses that pertain to wrist conditions, list using above format: _____

2. Medical history

a. Describe the history (including onset and course) of the Veteran's current wrist condition(s) (brief summary): _____

b. Dominant hand:
☐ Right ☐ Left ☐ Ambidextrous

3. Flare-ups

Does the Veteran report that flare-ups impact the function of the wrist?
☐ Yes ☐ No
If yes, document the Veteran's description of the impact of flare-ups in his or her own words: _____

4. Initial range of motion (ROM) measurements

Measure ROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the measurements, document the point at which painful motion begins, evidenced by visible behavior such as facial expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use testing must be included in all joint exams. The VA has determined that 3 repetitions of ROM (at a minimum) can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM after 3 repetitions. Report post-test measurements in section 5.

a. Right wrist palmar flexion
Select where palmar flexion ends (endpoint of palmar flexion is 80 degrees):

☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50
☐55 ☐60 ☐65 ☐70 ☐75 ☐80 or greater

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50
☐55 ☐60 ☐65 ☐70 or greater

b. Right wrist dorsiflexion (extension)
Select where dorsiflexion (extension) ends (endpoint of dorsiflexion (extension) is 70 degrees):
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50
☐55 ☐60 ☐65 ☐70 or greater

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50
☐55 ☐60 ☐65 ☐70 or greater

c. Left wrist palmar flexion
Select where palmar flexion ends (endpoint of palmar flexion is 80 degrees):
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50
☐55 ☐60 ☐65 ☐70 ☐75 ☐80 or greater

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50
☐55 ☐60 ☐65 ☐70 or greater

c. Left wrist dorsiflexion (extension)
Select where dorsiflexion (extension) ends (endpoint of dorsiflexion (extension) is 70 degrees):
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50
☐55 ☐60 ☐65 ☐70 or greater

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50
☐55 ☐60 ☐65 ☐70 or greater

e. If ROM does not conform to the normal range of motion identified above but is normal for this Veteran (for reasons other than a wrist condition, such as age, body habitus, neurologic disease), explain: _____

5. ROM measurements after repetitive use testing

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?
☐ Yes ☐ No If unable, provide reason: _____
If Veteran is unable to perform repetitive-use testing, skip to section 6.
If Veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions.

b. Right wrist post-test ROM
Select where palmar flexion ends:
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50
☐55 ☐60 ☐65 ☐70 ☐75 ☐80 or greater

Select where dorsiflexion (extension) ends:
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50
☐55 ☐60 ☐65 ☐70 or greater

c. Left wrist post-test ROM
Select where palmar flexion ends:
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50
☐55 ☐60 ☐65 ☐70 ☐75 ☐80 or greater

Select where dorsiflexion (extension) ends:
☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50
☐55 ☐60 ☐65 ☐70 or greater

6. Functional loss and additional limitation in ROM

The following section addresses reasons for functional loss, if present, and additional loss of ROM after repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance.

a. Does the Veteran have additional limitation in ROM of the wrist following repetitive-use testing?
☐ Yes ☐ No

b. Does the Veteran have any functional loss and/or functional impairment of the wrist?
☐ Yes ☐ No

c. If the Veteran has functional loss, functional impairment and/or additional limitation of ROM of the wrist after repetitive use, indicate the contributing factors of disability below (check all that apply and indicate side affected):

☐ No functional loss for right upper extremity
☐ No functional loss for left upper extremity
☐ Less movement than normal ☐ Right ☐ Left ☐ Both
☐ More movement than normal ☐ Right ☐ Left ☐ Both
☐ Weakened movement ☐ Right ☐ Left ☐ Both
☐ Excess fatigability ☐ Right ☐ Left ☐ Both
☐ Incoordination, ☐ Right ☐ Left ☐ Both
(impaired ability to execute skilled movements smoothly)
☐ Pain on movement ☐ Right ☐ Left ☐ Both
☐ Swelling ☐ Right ☐ Left ☐ Both
☐ Deformity ☐ Right ☐ Left ☐ Both
☐ Atrophy of disuse ☐ Right ☐ Left ☐ Both

7. Pain (pain on palpation)

Does the Veteran have localized tenderness or pain on palpation of joints/soft tissue of either wrist?
☐ Yes ☐ No
If yes, side affected: ☐ Right ☐ Left ☐ Both

8. Muscle strength testing

Rate strength according to the following scale:

0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance
5/5 Normal strength

Wrist flexion:	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Wrist extension:	Right:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left:	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5

9. Ankylosis

Does the Veteran have ankylosis of either wrist joint?

☐ Yes ☐ No

If yes, indicate severity and side affected:

☐ Extremely unfavorable	☐ Right	☐ Left	☐ Both
☐ Unfavorable, with ulnar or radial deviation	☐ Right	☐ Left	☐ Both
☐ Unfavorable, in any degree of palmar flexion	☐ Right	☐ Left	☐ Both
☐ Any other unfavorable position	☐ Right	☐ Left	☐ Both
☐ Favorable in 20º to 30º dorsiflexion	☐ Right	☐ Left	☐ Both

10. Joint replacement and/or other surgical procedures

a. Has the Veteran had a total wrist joint replacement?

☐ Yes ☐ No

If yes, indicate side and severity of residuals.

☐ Right wrist

Date of surgery: _____

Residuals:

☐ None

☐ Intermediate degrees of residual weakness, pain and/or limitation of motion

☐ Chronic residuals consisting of severe painful motion and/or weakness

☐ Other, describe: _____

☐ Left wrist

Date of surgery: _____

Residuals:

☐ None

☐ Intermediate degrees of residual weakness, pain or limitation of motion

☐ Chronic residuals consisting of severe painful motion or weakness

☐ Other, describe: _____

b. Has the Veteran had arthroscopic or other wrist surgery?

☐ Yes ☐ No

If yes, indicate side affected: ☐ Right ☐ Left ☐ Both

Date and type of surgery: _____

c. Does the Veteran have any residual signs and/or symptoms due to arthroscopic or other wrist surgery?

☐ Yes ☐ No

If yes, indicate side affected: ☐ Right ☐ Left ☐ Both

If yes, describe residuals: _____

11. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

☐ Yes ☐ No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

☐ Yes ☐ No

If yes, describe (brief summary): _____

12. Remaining effective function of the extremities

Due to the Veteran's wrist conditions, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc)

☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.
☐ No

If yes, indicate extremity(ies) (check all extremities for which this applies)**:**

☐ Right upper ☐ Left upper

For each checked extremity, describe loss of effective function, identify the condition causing loss of function, and provide specific examples (brief summary): _____

13. Diagnostic Testing

The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, no further imaging studies are indicated, even if arthritis has worsened.

a. Have imaging studies of the wrist been performed and are the results available?

☐ Yes ☐ No

If yes, is degenerative or traumatic arthritis documented?

☐ Yes ☐ No

If yes, indicate wrist: ☐ Right ☐ Left ☐ Both

b. Are there any other significant diagnostic test findings and/or results?

☐ Yes ☐ No

If yes, provide type of test or procedure, date and results (brief summary): _____

14. Functional impact

Does the Veteran's wrist condition impact his or her ability to work?

☐ Yes ☐ No

If yes, describe the impact of each of the Veteran's wrist conditions providing one or more examples:

_____

15. Remarks, if any: _____

Physician signature: _____ Date: ___
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

7. Software and Documentation Retrieval

7.1 Software

The VistA software is being distributed as a PackMan patch message through the National Patch Module (NPM). The KIDS build for this patch is DVBA*2.7*173.

7.2 User Documentation

The user documentation for this patch may be retrieved directly using FTP. The preferred method is to FTP the files from:

REDACTED

This transmits the files from the first available FTP server. Sites may also elect to retrieve software directly from a specific server as follows:

OI&T Field Office	FTP Address	Directory
Albany	REDACTED	[anonymous.software]
Hines	REDACTED	[anonymous.software]
Salt Lake City	REDACTED	[anonymous.software]

File Name	Format	Description
DVBA_27_P173_RN.PDF	Binary	Release Notes

7.3 Related Documents

The VistA Documentation Library (VDL) web site will also contain the DVBA*2.7*173 Release Notes. This web site is usually updated within 1-3 days of the patch release date.

The VDL web address for CAPRI documentation is: http://www.va.gov/vdl/application.asp?appid=133.

Content and/or changes to the DBQs are communicated by the Disability Examination Management Office (DEMO) through: http://vbacodmoint1.vba.va.gov/bl/21/DBQ/default.asp