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*172

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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*172. (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*172.

Patch DVBA *2.7*172 (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 ANKLE CONDITIONS**
- **DBQ DIABETES MELLITUS**
- **DBQ DIABETIC SENSORY- MOTOR PERIPHERAL NEUROPATHY**
- **DBQ EYE CONDITIONS**
- **DBQ HEART CONDITIONS: (INCLUDING ISCHEMIC & HEART DISEASE, ARRHYTHMIAS, VALVULAR DISEASE AND CARDIAC SURGERY)**
- **DBQ HYPERTENSION**
- **DBQ KNEE AND LOWER LEG CONDITIONS**
- **DBQ SCARS DISFIGUREMENT**
- **DBQ MEDICAL OPINION 1**
- **DBQ MEDICAL OPINION 2**
- **DBQ MEDICAL OPINION 3**
- **DBQ MEDICAL OPINION 4**
- **DBQ MEDICAL OPINION 5**
- **DBQ SHOULDER AND ARM CONDITIONS**
- **DBQ SKIN DISEASES**

This patch implements these new templates, which are accessible through the Compensations & Pension Worksheet Module (CPWM) of the CAPRI GUI.

3. Associated Remedy Tickets & New Service Requests

There are no Remedy tickets or New Service Requests associated with patch DVBA*2.7*172.

4. Defects Fixes

There are no CAPRI DBQ Templates or AMIE – DBQ Worksheet defects fixes associated with patch DVBA*2.7*172.

5. Enhancements

This section provides an overview of the modifications and primary functionality that will be delivered in Patch DVBA*2.7*172.

5.1 CAPRI – DBQ Template Additions

VBA VACO has approved the following new CAPRI Disability Benefit Questionnaire templates based on new C&P questionnaire worksheets.

- **DBQ ANKLE CONDITIONS**
- **DBQ DIABETES MELLITUS**
- **DBQ DIABETIC SENSORY-MOTOR PERIPHERAL NEUROPATHY**
- **DBQ EYE CONDITIONS**
- **DBQ HEART CONDITIONS: (INCLUDING ISCHEMIC & NON ISCHEMIC HEART DISEASE, ARRHYTHMIAS, VALVULAR DISEASE AND CARDIAC SURGERY)**
- **DBQ HYPERTENSION**
- **DBQ KNEE AND LOWER LEG CONDITIONS**
- **DBQ MEDICAL OPINION 1**
- **DBQ MEDICAL OPINION 2**
- **DBQ MEDICAL OPINION 3**
- **DBQ MEDICAL OPINION 4**
- **DBQ MEDICAL OPINION 5**
- **DBQ SCARS DISFIGUREMENT**
- **DBQ SHOULDER AND ARM CONDITIONS**
- **DBQ SKIN DISEASE**

5.2 CAPRI – DBQ Template Deactivation

VBA VACO Office has approved modifications to the following CAPRI Disability Benefits Questionnaire template based on a new C&P questionnaire worksheet.

- **DBQ MEDICAL OPINION**

The DBQ MEDICAL OPINION CAPRI CPWM template is being replaced with the DBQ MEDICAL OPINION 1, DBQ MEDICAL OPINION 2, DBQ MEDICAL OPINION 3, DBQ MEDICAL OPINION 4, and DBQ MEDICAL OPINION 5 templates to permit the ordering and completion of multiple Medical Opinions.

5.3 AMIE–DBQ Worksheet Additions

VBA VACO has approved the following new Automated Medical Information Exchange (AMIE) C&P Questionnaire worksheets.

- **DBQ ANKLE CONDITIONS**
- **DBQ DIABETES MELLITUS**
- **DBQ DIABETIC SENSORY-MOTOR PERIPHERAL NEUROPATHY**
- **DBQ EYE CONDITIONS**
- **DBQ HEART CONDITIONS**
- **DBQ HYPERTENSION**
- **DBQ KNEE AND LOWER LEG CONDITIONS**
- **DBQ MEDICAL OPINION 1**
- **DBQ MEDICAL OPINION 2**
- **DBQ MEDICAL OPINION 3**
- **DBQ MEDICAL OPINION 4**
- **DBQ MEDICAL OPINION 5**
- **DBQ SCARS DISFIGUREMENT**
- **DBQ SHOULDER AND ARM CONDITIONS**
- **DBQ SKIN DISEASE**

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 Deactivation

VBA VACO has approved deactivation of the following new Automated Medical Information Exchange (AMIE) C&P Questionnaire worksheet.

- **DBQ MEDICAL OPINION**

The DBQ MEDICAL OPINION AMIE Exam Worksheet is being replaced with the DBQ MEDICAL OPINION 1, DBQ MEDICAL OPINION 2, DBQ MEDICAL OPINION 3, DBQ MEDICAL OPINION 4, and DBQ MEDICAL OPINION 5 worksheets to permit the ordering and completion of multiple Medical Opinions.

6. Disability Benefits Questionnaires (DBQs)

The following section illustrates the content of the new questionnaires included in Patch DVBA*2.7*172.

6.1. DBQ Ankle 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 ankle condition?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to ankle condition(s):
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 ankle conditions, list using above format: _____

2. Medical history
Describe the history (including onset and course) of the Veteran's ankle condition (brief summary): ____

3. Flare-ups
Does the Veteran report that flare-ups impact the function of the ankle?
☐ 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 ankle plantar flexion

Select where plantar flexion ends (normal endpoint is 45 degrees):

☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 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 or greater

b. Right ankle dorsiflexion (extension)

Select where dorsiflexion (extension) ends (normal endpoint is 20 degrees):

☐0 ☐5 ☐10 ☐15 ☐20 or greater

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion

☐0 ☐5 ☐10 ☐15 ☐20 or greater

c. Left ankle plantar flexion

Select where plantar flexion ends (normal endpoint is 45 degrees):

☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 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 or greater

d. Left ankle plantar dorsiflexion (extension)

Select where dorsiflexion (extension) ends (normal endpoint is 20 degrees):

☐0 ☐5 ☐10 ☐15 ☐20 or greater

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion

☐0 ☐5 ☐10 ☐15 ☐20 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 ankle condition, such as age, body habitus, neurologic disease), explain: _____

5. ROM measurements after repetitive use testing

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.

a. Right ankle post-test ROM

Select where post-test plantar flexion ends:

☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 or greater

Select where post-test dorsiflexion (extension) ends:

☐0 ☐5 ☐10 ☐15 ☐20 or greater

b. Left ankle post-test ROM

Select where post-test plantar flexion ends:

☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 or greater

Select where post-test dorsiflexion (extension) ends:

☐0 ☐5 ☐10 ☐15 ☐20 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 ankle following repetitive-use testing?
☐ Yes ☐ No

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

c. If the Veteran has functional loss, functional impairment and/or additional limitation of ROM of the ankle 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 attributable to claimed condition
☐ No functional loss for left lower extremity attributable to claimed condition

☐ 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 weight-bearing	☐ Right	☐ Left	☐ Both

☐ Other, describe: _____

7. Pain (pain on palpation)

Does the Veteran have localized tenderness or pain on palpation of joints/soft tissue of either ankle?
☐ Yes ☐ No
If yes, indicate 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

Ankle plantar 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
Ankle dorsiflexion:	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. Joint stability

a. Anterior drawer test
Is there laxity compared with opposite side?
☐ Yes ☐ No ☐ Unable to test
If yes, which side demonstrates laxity? ☐ Right ☐ Left ☐ Both

b. Talar tilt test (inversion/eversion stress)
Is there laxity compared with opposite side?
☐ Yes ☐ No ☐ Unable to test
If yes, which side demonstrates laxity? ☐ Right ☐ Left ☐ Both

10. Ankylosis

Does the Veteran have ankylosis of the ankle, subtalar and/or tarsal joint?
☐ Yes ☐ No
If yes, indicate severity of ankylosis and side affected (check all that apply):

☐ In plantar flexion, less than 30º	☐ Right	☐ Left	☐ Both
☐ In plantar flexion, between 30º and 40º	☐ Right	☐ Left	☐ Both
☐ In plantar flexion, at more than 40º	☐ Right	☐ Left	☐ Both
☐ In dorsiflexion, between 0º and 10º	☐ Right	☐ Left	☐ Both
☐ In dorsiflexion, at more than 10º	☐ Right	☐ Left	☐ Both
☐ With abduction, adduction, inversion or eversion deformity	☐ Right	☐ Left	☐ Both
☐ In good weight-bearing position	☐ Right	☐ Left	☐ Both
☐ In poor weight-bearing position	☐ Right	☐ Left	☐ Both

11. Additional conditions

Does the Veteran now have or has he or she ever had "shin splints", stress fractures, Achilles tendonitis, Achilles tendon rupture, malunion of calcaneus (os calcis) or talus (astragalus), or has the Veteran had a talectomy (astragalectomy)?
☐ Yes ☐ No
If yes, indicate condition and complete the appropriate sections below: _____

a. ☐ "Shin splints" (medial tibial stress syndrome)
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both
Describe current symptoms: _____

b. ☐ Stress fracture of the lower extremity
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both
Describe current symptoms: _____

c. ☐ Achilles tendonitis or Achilles tendon rupture
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both
Describe current symptoms: _____

d. ☐ Malunion of calcaneous (os calcis) or talus (astragalus)
If checked, indicate severity and side affected:
☐ Moderate deformity ☐ Right ☐ Left ☐ Both
☐ Marked deformity ☐ Right ☐ Left ☐ Both

e. ☐ Talectomy _____
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both
Describe current symptoms: _____

12. Joint replacement and other surgical procedures

a. Has the Veteran had a total ankle joint replacement?
☐ Yes ☐ No
If yes, indicate side and severity of residuals.
☐ Right ankle
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 ankle
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 ankle 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 ankle surgery?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both
If yes, describe residuals: _____

13. 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): _____

14. 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: _____

15. Remaining effective function of the extremities

Due to the Veteran's ankle 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): _____

16. 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 ankle 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
ankle: ☐ Right ☐ Left ☐ Both
☐ Ankylosis
ankle: ☐ Right ☐ Left ☐ Both
☐ Other. Describe: _____
ankle: ☐ 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): _____

17. Functional impact

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

☐ Yes ☐ No

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

18. 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 Diabetes Mellitus

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

Select the Veteran's condition:

☐ Diabetes mellitus type I ICD code: _____ Date of diagnosis: _____
☐ Diabetes mellitus type II ICD code: _____ Date of diagnosis: _____
☐ Impaired fasting glucose ICD code: _____ Date of diagnosis: _____
☐ Does not meet criteria for diagnosis of diabetes
☐ Other (specify below), providing only diagnoses that pertain to DM or its complications:

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

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

2. Medical history

a. Treatment (check all that apply)

- ☐ None
- ☐ Managed by restricted diet
- ☐ Prescribed oral hypoglycemic agent(s)
- ☐ Prescribed insulin 1 injection per day
- ☐ Prescribed insulin more than 1 injection per day
- ☐ Other (describe): _____

b. Regulation of activities

Does the Veteran require regulation of activities as part of medical management of diabetes mellitus (DM)?

☐ Yes ☐ No

If yes, provide one or more examples of how the Veteran must regulate his or her activities: _____

NOTE: For VA purposes, regulation of activities can be defined as avoidance of strenuous occupational and recreational activities with the intention of avoiding hypoglycemic episodes.

c. Frequency of diabetic care

How frequently does the Veteran visit his or her diabetic care provider for episodes of ketoacidosis or hypoglycemic reactions?

☐ Less than 2 times per month ☐ 2 times per month ☐ Weekly

d. Hospitalizations for episodes of ketoacidosis or hypoglycemic reactions

How many episodes of ketoacidosis requiring hospitalization over the past 12 months?

☐ 0 ☐ 1 ☐ 2 ☐ 3 or more

How many episodes of hypoglycemia requiring hospitalization over the past 12 months?

☐ 0 ☐ 1 ☐ 2 ☐ 3 or more

e. Loss of strength and weight

Has the Veteran had progressive unintentional weight loss attributable to DM?

☐ Yes ☐ No

If yes, provide percent of loss of individual's baseline weight: _____%

NOTE: For VA purposes, “baseline weight” means the average weight for the two-year-period preceding the onset of the disease.

Has the Veteran had progressive loss of strength attributable to DM?

☐ Yes ☐ No

3. Complications of DM

a. Does the Veteran have any of the following recognized complications of DM?

☐ Yes ☐ No

If yes, indicate the conditions below: (check all that apply)

☐ Diabetic peripheral neuropathy
☐ Diabetic nephropathy or renal dysfunction caused by DM
☐ Diabetic retinopathy

For all checked boxes, also complete appropriate Questionnaire(s). (Eye Questionnaire must be completed by ophthalmologist or optometrist)

b. Does the veteran have any of the following conditions that are at least as likely as not (at least a 50% probability) due to DM?

☐ Yes ☐ No

If yes, indicate the conditions below: (check all that apply)

☐ Erectile dysfunction — If checked, also complete Male Reproductive Organs Questionnaire.
☐ Cardiac condition(s) — If checked, also complete appropriate cardiac Questionnaire (IHD or other cardiac Questionnaire).
☐ Hypertension (in the presence of diabetic renal disease) — If checked, also complete Hypertension Questionnaire.
☐ Peripheral vascular disease — If checked, also complete Arteries and Veins Questionnaire.
☐ Stroke — If checked, also complete appropriate neurologic Questionnaire(s) (Central Nervous System, Cranial nerves, etc.).
☐ Skin condition(s) — If checked, also complete Skin Questionnaire.
☐ Eye condition(s) other than diabetic retinopathy — If checked, also complete Eye Questionnaire. (Eye Questionnaire must be completed by ophthalmologist or optometrist)
☐ Other complication(s) (describe): _____

c. Has the Veteran’s DM at least as likely as not (at least a 50% probability) permanently aggravated (meaning that any worsening of the condition is not due to natural progress) any of the following conditions?

Check all that apply:

☐ Cardiac condition(s) — If checked, also complete appropriate cardiac Questionnaire (IHD or other cardiac Questionnaire).
☐ Hypertension — If checked, also complete Hypertension Questionnaire
☐ Renal disease — If checked, also complete Kidney Questionnaire
☐ Peripheral vascular disease — If checked, also complete Arteries and Veins Questionnaire.
☐ Eye condition(s) other than diabetic retinopathy — If checked, also complete Eye Questionnaire. (Eye Questionnaire must be completed by ophthalmologist or optometrist)
☐ Other permanently aggravated condition(s) (describe): _____
☐ None

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 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): _____

5. Diagnostic testing

NOTE: If laboratory test results are in the medical record, repeat testing is not required.
A glucose tolerance test is not required for VA purposes; report this test only if already completed.

Test results used to make the diagnosis of DM (if known): (check all that apply)

☐ Fasting plasma glucose test (FPG) of ≥126 mg/dl on 2 or more occasions Dates: _____

☐ A1C of 6.5% or greater on 2 or more occasions
Dates: _____

☐ 2-hr plasma glucose of ≥200 mg/dl on glucose tolerance test
Date: _____

☐ Random plasma glucose of ≥200 mg/dl with classic symptoms of hyperglycemia Date: _____

☐ Other, describe: _____

Current test results:

Most recent A1C, if available: _____ Date: _____

Most recent fasting plasma glucose, if available: _____ Date: _____

6. Functional impact

Does the Veteran's DM (and complications of DM if present) impact his or her ability to work?
(Impact on ability to work may also be addressed on the individual Questionnaire(s) for other diabetes-associated conditions and/or complications, if completed.)

☐ Yes ☐ No

If yes, separately describe impact of the Veteran's DM, diabetes-associated conditions, and complications, if present, 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 Diabetic Sensory- Motor Peripheral Neuropathy

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 been diagnosed with diabetic peripheral neuropathy?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to diabetic peripheral neuropathy:
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 diabetic peripheral neuropathy, list using above format: _____

2. Medical history

a. Does the Veteran have diabetes mellitus type I or type II?
☐ Yes ☐ No

b. Describe the history (including cause, onset and course) of the Veteran's diabetic peripheral neuropathy: _____

c. Dominant hand
☐ Right ☐ Left ☐ Ambidextrous

3. Symptoms

a. Does the Veteran have any symptoms attributable to diabetic peripheral neuropathy?
☐ Yes ☐ No
If yes, indicate symptoms' location and severity (check all that apply):

Constant pain (may be excruciating at times)

Right upper extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Left upper extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Right lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Left lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe

Intermittent pain (usually dull)

Right upper extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Left upper extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Right lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Left lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe

Paresthesias and/or dysesthesias

Right upper extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Left upper extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Right lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Left lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe

Numbness

Right upper extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Left upper extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Right lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Left lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe

b. ☐ Other symptoms (describe symptoms, location and severity): _____

4. Neurologic exam

a. Strength

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

☐ All normal

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
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
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
Pinch (thumb to index finger):							
	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:	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:	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:	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:	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

b. Deep tendon reflexes (DTRs)

Rate reflexes according to the following scale:

0 Absent
1+ Decreased

2+ Normal
3+ Increased without clonus
4+ Increased with clonus

☐ All normal

Biceps:	Right:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	Left:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Triceps:	Right:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	Left:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Brachioradialis:	Right:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	Left:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Knee:	Right:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	Left:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Ankle:	Right:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	Left:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+

c. Light touch/monofilament testing results:

☐ All normal

Shoulder area:	Right:	☐ Normal	☐ Decreased	☐ Absent
	Left:	☐ Normal	☐ Decreased	☐ Absent
Inner/outer forearm:	Right:	☐ Normal	☐ Decreased	☐ Absent
	Left:	☐ Normal	☐ Decreased	☐ Absent
Hand/fingers:	Right:	☐ Normal	☐ Decreased	☐ Absent
	Left:	☐ Normal	☐ Decreased	☐ Absent
Knee/thigh:	Right:	☐ Normal	☐ Decreased	☐ Absent
	Left:	☐ Normal	☐ Decreased	☐ Absent
Ankle/lower leg:	Right:	☐ Normal	☐ Decreased	☐ Absent
	Left:	☐ Normal	☐ Decreased	☐ Absent
Foot/toes:	Right:	☐ Normal	☐ Decreased	☐ Absent
	Left:	☐ Normal	☐ Decreased	☐ Absent

d. Position sense (grasp index finger/great toe on sides and ask patient to identify up and down movement)

☐ Not tested

Right upper extremity:	☐ Normal	☐ Decreased	☐ Absent
Left upper extremity:	☐ Normal	☐ Decreased	☐ Absent
Right lower extremity:	☐ Normal	☐ Decreased	☐ Absent
Left lower extremity:	☐ Normal	☐ Decreased	☐ Absent

e. Vibration sensation (place low-pitched tuning fork over DIP joint of index finger/ IP joint of great toe)

☐ Not tested

Right upper extremity:	☐ Normal	☐ Decreased	☐ Absent
Left upper extremity:	☐ Normal	☐ Decreased	☐ Absent
Right lower extremity:	☐ Normal	☐ Decreased	☐ Absent
Left lower extremity:	☐ Normal	☐ Decreased	☐ Absent

f. Cold sensation (test distal extremities for cold sensation with side of tuning fork)

☐ Not tested

Right upper extremity:	☐ Normal	☐ Decreased	☐ Absent
Left upper extremity:	☐ Normal	☐ Decreased	☐ Absent
Right lower extremity:	☐ Normal	☐ Decreased	☐ Absent
Left lower extremity:	☐ Normal	☐ Decreased	☐ Absent

g. Does the Veteran have muscle atrophy?

☐ Yes ☐ No

If muscle atrophy is present, indicate location: _____

For each instance of muscle atrophy, provide measurementsin cm between normal and atrophied side, measured at maximum muscle bulk: _____ cm.

h. Does the Veteran have trophic changes (characterized by loss of extremity hair, smooth, shiny skin, etc.) attributable to diabetic peripheral neuropathy?
☐ Yes ☐ No
If yes, describe: _____

5. Severity
NOTE: Based on symptoms and findings from Sections 3 and 4, complete items a and b below to provide an evaluation of the severity of the Veteran's diabetic peripheral neuropathy.

NOTE: For VA purposes, the term "incomplete paralysis" indicates a degree of lost or impaired function substantially less than the description of complete paralysis that is given with each nerve.

If the nerve is completely paralyzed, check the box for "complete paralysis." If the nerve is not completely paralyzed, check the box for "incomplete paralysis" and indicate severity. For VA purposes, when nerve impairment is wholly sensory, the evaluation should be mild, or at most, moderate.

a. Does the Veteran have an upper extremity diabetic peripheral neuropathy?

☐ Yes ☐ No

If yes, indicate nerve affected, severity and side affected:

Radial nerve (musculospiral nerve)

Note: Complete paralysis (hand and fingers drop, wrist and fingers flexed; cannot extend hand at wrist, extend proximal phalanges of fingers, extend thumb or make lateral movement of wrist; supination of hand, elbow extension and flexion weak, hand grip impaired)

☐ Right:

☐ Normal ☐ Incomplete paralysis ☐ Complete paralysis
If Incomplete paralysis is checked, indicate severity:
☐ Mild ☐ Moderate ☐ Severe

☐ Left:

☐ Normal ☐ Incomplete paralysis ☐ Complete paralysis
If Incomplete paralysis is checked, indicate severity:
☐ Mild ☐ Moderate ☐ Severe

Median nerve

Note: Complete paralysis (hand inclined to the ulnar side, index and middle fingers extended, atrophy of thenar eminence, cannot make fist, defective opposition of thumb, cannot flex distal phalanx of thumb; wrist flexion weak)

☐ Right:

☐ Normal ☐ Incomplete paralysis ☐ Complete paralysis
If Incomplete paralysis is checked, indicate severity:
☐ Mild ☐ Moderate ☐ Severe

☐ Left:

☐ Normal ☐ Incomplete paralysis ☐ Complete paralysis
If Incomplete paralysis is checked, indicate severity:
☐ Mild ☐ Moderate ☐ Severe

Ulnar nerve
Note: Complete paralysis ("griffin claw" deformity, atrophy in dorsal interspaces, thenar and hypothenar eminences; cannot extend ring and little finger, cannot spread fingers, cannot adduct the thumb; wrist flexion weakened).

☐ Right:
☐ Normal ☐ Incomplete paralysis ☐ Complete paralysis
If Incomplete paralysis is checked, indicate severity:
☐ Mild ☐ Moderate ☐ Severe

☐ Left:
☐ Normal ☐ Incomplete paralysis ☐ Complete paralysis
If Incomplete paralysis is checked, indicate severity:
☐ Mild ☐ Moderate ☐ Severe

b. Does the Veteran have a lower extremity diabetic peripheral neuropathy?

☐ Yes ☐ No

If yes, indicate nerve affected, severity and side affected:

Sciatic nerve
Note: Complete paralysis (foot dangles and drops, no active movement of muscles below the knee, flexion of knee weakened or lost).

☐ Right:
☐ Normal ☐ Incomplete paralysis ☐ Complete paralysis
If Incomplete paralysis is checked, indicate severity:
☐ Mild ☐ Moderate ☐ Moderately severe ☐ Severe, with marked muscular atrophy

☐ Left:
☐ Normal ☐ Incomplete paralysis ☐ Complete paralysis
If Incomplete paralysis is checked, indicate severity:
☐ Mild ☐ Moderate ☐ Moderately severe ☐ Severe, with marked muscular atrophy

Femoral nerve (anterior crural)
Note: Complete paralysis (paralysis of quadriceps extensor muscles).

☐ Right:
☐ Normal ☐ Incomplete paralysis ☐ Complete paralysis
If Incomplete paralysis is checked, indicate severity:
☐ Mild ☐ Moderate ☐ Severe

☐ Left:
☐ Normal ☐ Incomplete paralysis ☐ Complete paralysis
If Incomplete paralysis is checked, indicate severity:
☐ Mild ☐ Moderate ☐ Severe

6. 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): _____

7. Diagnostic testing

For purpose of this examination, electromyography (EMG) studies are rarely required to diagnose diabetic peripheral neuropathy. The diagnosis of diabetic peripheral neuropathy can be made in the appropriate clinical setting by a history of characteristic pain and/or sensory changes in a stocking/glove distribution and objective clinical findings, which may include symmetrical lost/decreased reflexes, decreased strength, lost/decreased sensation for cold, vibration and/or position sense, and/or lost/decreased sensation to monofilament testing.

a. Have EMG studies been performed?

☐ Yes ☐ No

Extremities tested:

☐ Right upper extremity	Results: ☐ Normal	☐ Abnormal	Date: _____
☐ Left upper extremity	Results: ☐ Normal	☐ Abnormal	Date: _____
☐ Right lower extremity	Results: ☐ Normal	☐ Abnormal	Date: _____
☐ Left lower extremity	Results: ☐ Normal	☐ Abnormal	Date: _____

If abnormal, describe: _____

b. If there are other significant findings or diagnostic test results, provide dates and describe: _____

8. Functional impact

Does the Veteran's diabetic peripheral neuropathy impact his or her ability to work?

☐ Yes ☐ No

If yes, describe impact of the Veteran's diabetic peripheral neuropathy, providing one or more examples: _____

9. 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 Eye 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.

SECTION I: DIAGNOSES
NOTE: The diagnosis section should be filled out AFTER the clinician has completed the examination

Does the Veteran now have or has he/she ever been diagnosed with an eye condition (other than congenital or developmental errors of refraction)?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to eye 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 eye conditions, list using above format: _____

SECTION II: MEDICAL HISTORY
Describe the history (including onset and course) of the Veteran's current eye condition(s) (brief summary):
_____

SECTION III: PHYSICAL EXAMINATION

1. Visual acuity
Visual acuity should be reported according to the lines on the Snellen chart or its equivalent. If assessment of the Veteran's visual acuity falls between two lines on the Snellen chart, round up to the higher (worse) level (poorer vision) for answers a-d below. (For example, 20/60 would be reported as 20/70; 20/80 would be reported as 20/100, etc.)

Examination of visual acuity must include central uncorrected and corrected visual acuity for distance and near vision. Evaluate central visual acuity on the basis of corrected distance vision with central fixation. Visual acuity should not be determined with eccentric fixation or viewing.

a. Uncorrected distance:
Right: ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better
Left: ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

b. Uncorrected near:
Right: ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better
Left: ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

c. Corrected distance:
Right: ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better
Left: ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

d. Corrected near:
Right: ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better
Left: ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

2. Difference in corrected visual acuity for distance and near vision

Does the Veteran have a difference equal to two or more lines on the Snellen test type chart or its equivalent between distance and near corrected vision, with the near vision being worse?
☐ Yes ☐ No
If yes, complete the following section:

a. Provide a second recording of corrected distance and near vision:
Second recording of corrected distance vision:
Right: ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better
Left: ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

Second recording of corrected near vision:
Right: ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better
Left: ☐ 5/200 ☐ 10/200 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

b. Explain reason for the difference between distance and near corrected vision: _____

c. Does the lens required to correct distance vision in the poorer eye differ by more than 3 diopters from the lens required to correct distance vision in the better eye?
☐ Yes ☐ No
If yes, explain reason for the difference: _____

3. Pupils

a. Pupil diameter: Right: _____mm Left: _____mm

b. ☐ Pupils are round and reactive to light

c. Is an afferent pupillary defect present?
☐ Yes ☐ No
If yes, indicate eye: ☐ Right ☐ Left

d. ☐ Other, describe: _____
Eye affected: ☐ Right ☐ Left ☐ Both

4. Anatomical loss, light perception only, extremely poor vision or blindness

Does the Veteran have anatomical loss, light perception only, extremely poor vision or blindness of either eye?
☐ Yes ☐ No
If yes, complete the following section:

a. Does the Veteran have anatomical loss of either eye?
☐ Yes ☐ No
If yes, indicate eye:
☐ Right ☐ Left ☐ Both
If yes, is Veteran able to wear an ocular prosthesis?
☐ Yes ☐ No
If no, provide reason: _____

b. Is the Veteran's vision limited to no more than light perception only in either eye?
☐ Yes ☐ No
If yes, indicate for which eye(s) the Veteran's vision limited to no more than light perception:
☐ Right ☐ Left ☐ Both

c. Is the Veteran able to recognize test letters at 1 foot or closer?
☐ Yes ☐ No
If no, indicate with which eye(s) the Veteran is unable to recognize test letters at 1 foot or closer:
☐ Right ☐ Left ☐ Both

d. Is the Veteran able to perceive objects, hand movements, or count fingers at 3 feet?
☐ Yes ☐ No
If no, indicate with which eye(s) the Veteran is unable to perceive objects, hand movements, or count fingers at 3 feet:
☐ Right ☐ Left ☐ Both

e. Does the Veteran have visual acuity of 20/200 or less in the better eye with use of a correcting lens based upon visual acuity loss (i.e. USA statutory blindness with bilateral visual acuity of 20/200 or less)?
☐ Yes ☐ No

5. Astigmatism
Does the Veteran have a corneal irregularity that results in severe irregular astigmatism?
☐ Yes ☐ No
If yes, complete the following section:

a. Does the Veteran customarily wear contact lenses to correct the above corneal irregularity?
☐ Yes ☐ No
If yes, does using contact lenses result in more visual improvement than using the standard spectacle correction?
☐ Yes ☐ No

b. Was the corrected visual acuity determined using contact lenses?
☐ Yes ☐ No
If no, explain: _____

6. Diplopia
Does the Veteran have diplopia (double vision)?
☐ Yes ☐ No
If yes, complete the following section:

a. Provide etiology (such as traumatic injury, thyroid eye disease, myasthenia gravis, etc.): _____
b. The areas of diplopia must be documented on a Goldmann perimeter chart that identifies the four major quadrants (upward, downward, left lateral and right lateral) and the central field (20 degrees or less). Include the chart with this Questionnaire.
Report the results from the Goldmann perimeter chart below:

Indicate the areas where diplopia is present (the fields in which the Veteran sees double using binocular vision):
- ☐ Central 20 degrees
- ☐ 21 to 30 degrees
  - ☐ Down
  - ☐ Lateral
  - ☐ Up
- ☐ 31 to 40 degrees
  - ☐ Down
  - ☐ Lateral
  - ☐ Up
- ☐ Greater than 40 degrees

☐ Down
☐ Lateral
☐ Up

c. Indicate frequency of the diplopia:
☐ Constant ☐ Occasional
If occasional, indicate frequency of diplopia and most recent occurrence: _____

d. Is the diplopia correctable with standard spectacle correction?
☐ Yes ☐ No
If no, is the diplopia correctable with standard spectacle correction that includes a special prismatic correction?
☐ Yes ☐ No

7. Tonometry
a. If tonometry was performed, provide results:
Right eye pressure: _____ Left eye pressure: _____

b. Tonometry method used:
☐ Goldmann applanation
☐ Other, describe: _____

8. Slit lamp and external eye exam
a. External exam/lids/lashes:
Right ☐ Normal ☐ Other, describe: _____
Left ☐ Normal ☐ Other, describe: _____
b. Conjunctiva/sclera:
Right ☐ Normal ☐ Other, describe: _____
Left ☐ Normal ☐ Other, describe: _____
c. Cornea:
Right ☐ Normal ☐ Other, describe: _____
Left ☐ Normal ☐ Other, describe: _____
d. Anterior chamber
Right ☐ Normal ☐ Other, describe: _____
Left ☐ Normal ☐ Other, describe: _____
e. Iris:
Right ☐ Normal ☐ Other, describe: _____
Left ☐ Normal ☐ Other, describe: _____
f. Lens:
Right ☐ Normal ☐ Other, describe: _____
Left ☐ Normal ☐ Other, describe: _____

9. Internal eye exam (fundus)
Fundus:
☐ Normal bilaterally ☐ Abnormal
If checked, complete the following section:
a. Optic disc:
Right ☐ Normal ☐ Other, describe: _____
Left ☐ Normal ☐ Other, describe: _____
b. Macula:
Right ☐ Normal ☐ Other, describe: _____
Left ☐ Normal ☐ Other, describe: _____
c. Vessels
Right ☐ Normal ☐ Other, describe: _____
Left ☐ Normal ☐ Other, describe: _____
d. Vitreous:
Right ☐ Normal ☐ Other, describe: _____

Left ☐ Normal ☐ Other, describe: _____

e. Periphery:

Right ☐ Normal ☐ Other, describe: _____

Left ☐ Normal ☐ Other, describe: _____

10. Visual fields

Does the Veteran have a visual field defect (or a condition that may result in visual field defect)?

☐ Yes ☐ No

If yes, complete the following section:

NOTE: For VA purposes, examiners must perform visual field testing using either Goldmann kinetic perimetry or automated perimetry using Humphrey Model 750, Octopus Model 101 or later versions of these perimetric devices with simulated kinetic Goldmann testing capability. The results must be recorded on a standard Goldmann chart providing at least 16 meridians 22½ degrees apart for each eye and included with this Questionnaire.

If additional testing is necessary to evaluate visual fields, it must be conducted using either a tangent screen or a 30-degree threshold visual field with the Goldmann III stimulus size. The examination report must then include the tracing of either the tangent screen or of the 30-degree threshold visual field with the Goldmann III stimulus size.

a. Was visual field testing performed?

☐ Yes ☐ No

Results:

☐ Using Goldmann's equivalent III/4e target

☐ Using Goldmann's equivalent IV/4e target (used for aphakic individuals not well adapted to contact lens correction or pseudophakic individuals not well adapted to intraocular lens implant)

☐ Other, describe: _____

b. Does the Veteran have contraction of a visual field?

☐ Yes ☐ No

If yes, include Goldmann chart with this Questionnaire.

c. Does the Veteran have loss of a visual field?

☐ Yes ☐ No

If yes, check all that apply and indicate eye affected:

☐ Homonymous hemianopsia	☐ Right	☐ Left	☐ Both
☐ Loss of temporal half of visual field	☐ Right	☐ Left	☐ Both
☐ Loss of nasal half of visual field	☐ Right	☐ Left	☐ Both
☐ Loss of inferior half of visual field	☐ Right	☐ Left	☐ Both
☐ Loss of superior half of visual field	☐ Right	☐ Left	☐ Both
☐ Other, specify: _____	☐ Right	☐ Left	☐ Both

d. Does the Veteran have a scotoma?

☐ Yes ☐ No

If yes, check all that apply and indicate eye affected:

☐ Scotoma affecting at least 1/4 of the visual field	☐ Right	☐ Left	☐ Both
☐ Centrally located scotoma	☐ Right	☐ Left	☐ Both

e. Does the Veteran have legal (statutory) blindness (visual field diameter of 20 degrees or less in the better eye, even if the corrected visual acuity is 20/20) based upon visual field loss?

☐ Yes ☐ No

SECTION IV: Eye conditions

1. Conditions

Does the Veteran have any of the following eye conditions?

☐ Yes ☐ No

If no, proceed to Section V.
If yes, check all that apply:

☐ Anatomical loss of eyelids, brows, lashes (If checked, complete # 2 below)
☐ Lacrimal gland and lid disorders (other than ptosis or anatomic loss) (If checked, complete # 3 below)
☐ Ptosis, for either or both eyelids (If checked, complete # 4 below)
☐ Conjunctivitis and other conjunctival conditions (If checked, complete # 5 below)
☐ Corneal conditions (If checked, complete # 6 below)
☐ Cataract and other lens conditions (If checked, complete # 7 below)
☐ Inflammatory eye conditions and/or injuries (If checked, complete # 8 below)
☐ Glaucoma (If checked, complete # 9 below)
☐ Optic neuropathy and other disc conditions (If checked, complete # 10 below)
☐ Retinal conditions (If checked, complete # 11 below)
☐ Neurologic eye conditions (If checked, complete # 12 below)
☐ Tumors and neoplasms (If checked, complete # 13 below)
☐ Other eye conditions (If checked, complete # 14 below)

For each checked answer, complete the appropriate section (2-14) below:

2. Anatomical loss of eyelids, brows, lashes

a. Indicate condition and side affected (check all that apply):

☐ Partial or complete loss of eyelid Side affected: ☐ Right ☐ Left ☐ Both
☐ Complete loss of eyebrows Side affected: ☐ Right ☐ Left ☐ Both
☐ Complete loss of eyelashes Side affected: ☐ Right ☐ Left ☐ Both

b. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to eyelid loss?
☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment
If no, explain: _____

c. If present, does eyelid loss cause scarring or disfigurement?
☐ Yes ☐ No
If yes, complete Section IV, Scarring and disfigurement.

3. Lacrimal gland and lid conditions

a. Indicate the Veteran's condition(s) and side affected (check all that apply):

☐ Ectropion Side affected: ☐ Right ☐ Left ☐ Both
☐ Entropion Side affected: ☐ Right ☐ Left ☐ Both
☐ Lagophthalmos Side affected: ☐ Right ☐ Left ☐ Both
☐ Disorder of the lacrimal apparatus (epiphora, dacryocystitis, etc.)
If checked, specify condition: _____
Side affected: ☐ Right ☐ Left ☐ Both

b. If present, does lacrimal or lid condition cause scarring or disfigurement?
☐ Yes ☐ No
If yes, complete Section IV, Scarring and disfigurement.

4. Ptosis

a. If ptosis is present, indicate side affected: ☐ Right ☐ Left ☐ Both

b. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to ptosis?
☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment
If no, explain: _____

c. Does the ptosis cause disfigurement?
☐ Yes ☐ No
If yes, complete Section IV, Scarring and disfigurement.

5. Conjunctivitis and other conjunctival conditions

a. Indicate type of conjunctivitis, activity, and side affected (check all that apply):
☐ Trachomatous:
☐ Active Eye affected: ☐ Right ☐ Left ☐ Both
☐ Inactive Eye affected: ☐ Right ☐ Left ☐ Both
☐ Nontrachomatous:
☐ Active Eye affected: ☐ Right ☐ Left ☐ Both
☐ Inactive Eye affected: ☐ Right ☐ Left ☐ Both

b. Indicate the Veteran's other conjunctival conditions, if any (check all that apply):
☐ Pinguecula Eye affected: ☐ Right ☐ Left ☐ Both
☐ Symblepharon Eye affected: ☐ Right ☐ Left ☐ Both
☐ Other, describe: _____
Eye affected: ☐ Right ☐ Left ☐ Both

c. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the eye conditions checked above in this section?
☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment
If no, explain: _____

d. Does any eye condition identified in this section cause scarring or disfigurement?
☐ Yes ☐ No
If yes, complete Section IV, Scarring and disfigurement.

6. Corneal conditions
a. Has the Veteran had a corneal transplant?
☐ Yes ☐ No
If yes, indicate side of transplant: ☐ Right ☐ Left ☐ Both
Indicate residuals (check all that apply):
☐ Pain Eye affected: ☐ Right ☐ Left ☐ Both
☐ Photophobia Eye affected: ☐ Right ☐ Left ☐ Both
☐ Glare sensitivity Eye affected: ☐ Right ☐ Left ☐ Both
☐ Other, describe: _____
Eye affected: ☐ Right ☐ Left ☐ Both

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

c. Does the Veteran have a pterygium?
☐ Yes ☐ No
If yes, indicate eye affected: ☐ Right ☐ Left ☐ Both

d. Does the Veteran have another corneal condition that may result in an irregular cornea?
(For example, pellucid marginal degeneration, irregular astigmatism from corneal scar, post-laser refractive surgery, acne rosacea keratopathy, etc.)
☐ Yes ☐ No
If yes, specify corneal condition: _____
Eye affected: ☐ Right ☐ Left ☐ Both

e. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to keratoconus or

another corneal condition, if present?
☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment
If yes, specify corneal condition responsible for visual impairment _____.
If no, explain: _____

f. Does any eye condition identified in this section cause scarring or disfigurement?
☐ Yes ☐ No
If yes, complete Section IV, Scarring and disfigurement.

7. Cataract and other lens conditions

a. Indicate cataract condition:
- ☐ Preoperative (cataract is present)
  Eye affected: ☐ Right ☐ Left ☐ Both
- ☐ Postoperative (cataract has been removed)
  Eye affected: ☐ Right ☐ Left ☐ Both
  Is there a replacement intraocular lens?
  ☐ Yes ☐ No
  If yes, indicate eye: ☐ Right ☐ Left ☐ Both

b. Is there aphakia or dislocation of the crystalline lens?
☐ Yes ☐ No
If yes, indicate eye: ☐ Right ☐ Left ☐ Both

c. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the eye conditions checked above in this section?
☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment
If yes, specify condition in this section responsible for visual impairment _____.

If no, explain: _____

8. Inflammatory eye conditions and/or injuries

a. Indicate the Veteran's condition and eye affected:

☐ Choroidopathy (including uveitis, iritis, cyclitis, and choroiditis)	☐ Right ☐ Left ☐ Both
☐ Keratopathy	☐ Right ☐ Left ☐ Both
☐ Scleritis	☐ Right ☐ Left ☐ Both
☐ Intraocular hemorrhage	☐ Right ☐ Left ☐ Both
☐ Unhealed eye injury	☐ Right ☐ Left ☐ Both
☐ Other, describe: _____	☐ Right ☐ Left ☐ Both

b. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to any eye condition checked above in this section?
☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment
If yes, specify inflammatory or traumatic condition responsible for visual impairment _____.
If no, explain: _____

c. Does any eye condition identified in this section cause scarring or disfigurement?
☐ Yes ☐ No
If yes, complete Section IV, Scarring and disfigurement.

9. Glaucoma

a. Specify the type of glaucoma:
- ☐ Angle-closure Eye affected: ☐ Right ☐ Left ☐ Both
- ☐ Open-angle Eye affected: ☐ Right ☐ Left ☐ Both
- ☐ Other, specify type (For example, neovascular, phakolytic, etc.) _____
  Eye affected: ☐ Right ☐ Left ☐ Both

b. Does the glaucoma require continuous medication for treatment?
☐ Yes ☐ No
If yes, indicate eye affected: ☐ Right ☐ Left ☐ Both
List medication(s) used for treatment of glaucoma: _____

c. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to glaucoma?
☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment
If no, explain: _____

d. Does any glaucoma condition identified in this section cause scarring or disfigurement?
☐ Yes ☐ No
If yes, complete Section IV, Scarring and disfigurement.

10. Optic neuropathy and other disc conditions

a. Indicate optic neuropathy and other disc conditions, and eye affected: (check all that apply)

☐ Drusen of optic disc	☐ Right ☐ Left ☐ Both
☐ Ischemic optic neuropathy	☐ Right ☐ Left ☐ Both
☐ Nutritional optic neuropathy	☐ Right ☐ Left ☐ Both
☐ Optic atrophy	☐ Right ☐ Left ☐ Both
☐ Other, describe _____	☐ Right ☐ Left ☐ Both

b. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the above checked eye conditions?
☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment
If yes, specify optic neuropathy or disc condition responsible for visual impairment _____
If no, explain: _____

11. Retinal conditions

a. Indicate retinal condition, and eye affected: (check all that apply)

☐ Retinopathy	☐ Right ☐ Left ☐ Both
☐ Maculopathy	☐ Right ☐ Left ☐ Both
☐ Detached retina	☐ Right ☐ Left ☐ Both
☐ Retinal hemorrhage	☐ Right ☐ Left ☐ Both
☐ Centrally located retinal scars, atrophy or irregularities in either eye that result in an irregular, duplicated, enlarged or diminished image in either eye	☐ Right ☐ Left ☐ Both

b. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the above checked eye conditions?
☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment
If yes, specify retinal condition responsible for visual impairment _____
If no, explain: _____

12. Neurologic eye conditions

a. Indicate the Veteran's neurologic eye condition/disorder:
- ☐ Nystagmus
  - If checked, is nystagmus etiology central? ☐ Yes ☐ No
- ☐ Paresis/paralysis of 3rd cranial nerve (oculomotor)
  - Eye affected: ☐ Right ☐ Left ☐ Both
- ☐ Paresis/paralysis of 4th cranial nerve (trochlear)
  - Eye affected: ☐ Right ☐ Left ☐ Both
- ☐ Paresis/paralysis of 6th cranial nerve (abducens)
  - Eye affected: ☐ Right ☐ Left ☐ Both
- ☐ Paresis/paralysis of 7th cranial nerve (facial, Bell's palsy)
  - Eye affected: ☐ Right ☐ Left ☐ Both

☐ Eye condition due to cerebrovascular accident (CVA)
If checked, specify eye condition attributable to CVA: _____
Eye affected: ☐ Right ☐ Left ☐ Both
☐ Eye condition due to demyelinating disease
If checked, specify eye condition attributable to demyelinating disease: _____
Eye affected: ☐ Right ☐ Left ☐ Both
☐ Optic neuritis
Eye affected: ☐ Right ☐ Left ☐ Both
☐ Eye condition due to intracranial mass/tumor
If checked, specify eye condition attributable to intracranial mass/tumor: _____
Eye affected: ☐ Right ☐ Left ☐ Both
☐ Eye disorder due to traumatic brain injury (TBI)
If checked, specify eye condition attributable to TBI: _____
Eye affected: ☐ Right ☐ Left ☐ Both
☐ Other
If checked, specify neurologic eye condition/disorder and name the underlying neurologic condition (for example, Alzheimer's disease, Jakob-Creutzfeldt disease, etc.): _____
Eye affected: ☐ Right ☐ Left ☐ Both

b. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the neurologic eye conditions checked above in this section?
☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment
If yes, specify condition in this section responsible for visual impairment _____.
If no, explain: _____

13. Tumors and neoplasms
Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?
☐ Yes ☐ No
If yes, complete the following:

a. Is the neoplasm:
☐ Benign ☐ Malignant

b. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?
☐ Yes ☐ No; watchful waiting
If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):
☐ Treatment completed; currently in watchful waiting status
☐ Surgery
If checked, describe: _____
Date(s) of surgery: _____
☐ Radiation therapy
Date of most recent treatment: _____
Date of completion of treatment or anticipated date of completion: _____
☐ Antineoplastic chemotherapy
Date of most recent treatment: _____
Date of completion of treatment or anticipated date of completion: _____ _____
☐ Other therapeutic procedure
If checked, describe procedure: _____
Date of most recent procedure: _____
☐ Other therapeutic treatment
If checked, describe treatment:
Date of completion of treatment or anticipated date of completion: _____

c. Does the Veteran currently have any residual conditions or complications due to the neoplasm (including

metastases) or its treatment, other than those already documented in the report above?
☐ Yes ☐ No
If yes, list residual conditions and complications (brief summary): _____

d. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the Diagnosis section, describe using the above format: _____

e. Does any benign or malignant neoplasms or metastases identified in this section cause scarring or disfigurement?

☐ Yes ☐ No

If yes, complete Section IV, Scarring and disfigurement.

14. Other eye conditions, pertinent physical findings, complications, conditions, signs and/or symptoms
Does the Veteran have any other eye conditions, pertinent physical findings, complications, conditions, signs and/or symptoms related to the condition at hand?
☐ Yes ☐ No
If yes, describe: _____

SECTION V: Scarring and disfigurement
Does the Veteran have scarring or disfigurement attributable to any eye condition?
☐ Yes ☐ No
If yes, indicate scar attributes (check all that apply):
- ☐ Scar at least one-quarter inch (0.6 cm.) wide at widest part
- ☐ Surface contour of scar elevated or depressed on palpation (or inspection in the case of cornea or sclera)
- ☐ Scar adherent to underlying tissue (including eyelids adherent to scleral tissue)
- ☐ Visible or palpable tissue loss
- ☐ Gross distortion or asymmetry of one feature or paired set of features (eyes)

For all checked conditions, describe scarring and/or disfigurement: _____

NOTE: If possible, include color photographs with any report of scarring or disfigurement.

SECTION VI: Incapacitating episodes
During the past 12 months, has the Veteran had any incapacitating episodes attributable to any eye conditions?
NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician or other healthcare provider (For example, temporary bed rest required for a retinal condition.)
☐ Yes ☐ No
If yes, specify the eye condition(s) causing incapacitating episodes: _____
Describe how the eye condition(s) caused incapacitating episodes: _____

Provide the total duration for the incapacitating episodes for all incapacitating conditions over the past 12 months:
- ☐ Less than 1 week
- ☐ At least 1 week but less than 2 weeks
- ☐ At least 2 weeks but less than 4 weeks
- ☐ At least 4 weeks but less than 6 weeks
- ☐ At least 6 weeks

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

2. Remarks, if any: _____

Optometrist/Physician signature: _____ Date: _____
Optometrist/Physician printed name: _____
Optometric/Medical license #: _____ State of licensure: _____
Optometrist/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 Heart Conditions: (including Ischemic & Heart Disease, Arrhythmias, Valvular Disease and Cardiac Surgery

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 been diagnosed with a heart condition?

☐ Yes ☐ No

If yes, select the Veteran's heart condition(s) (check all that apply):

☐ Acute, subacute, or old myocardial infarction
ICD code: _____ Date of diagnosis: _____

☐ Atherosclerotic cardiovascular disease
ICD code: _____ Date of diagnosis: _____

☐ Coronary artery disease
ICD code: _____ Date of diagnosis: _____

☐ Stable angina ICD code: _____ Date of diagnosis: _____

☐ Unstable angina ICD code: _____ Date of diagnosis: _____

☐ Coronary spasm, including Prinzmetal's angina
ICD code: _____ Date of diagnosis: _____

☐ Congestive heart failure ICD code: _____ Date of diagnosis: _____

☐ Supraventricular arrhythmia ICD code: _____ Date of diagnosis: _____

☐ Ventricular arrhythmia ICD code: _____ Date of diagnosis: _____

☐ Heart block ICD code: _____ Date of diagnosis: _____

☐ Valvular heart disease ICD code: _____ Date of diagnosis: _____

☐ Heart valve replacement ICD code: _____ Date of diagnosis: _____

☐ Cardiomyopathy ICD code: _____ Date of diagnosis: _____

☐ Hypertensive heart disease ICD code: _____ Date of diagnosis: _____

☐ Heart transplant ICD code: _____ Date of diagnosis: _____

☐ Implanted cardiac pacemaker ICD code: _____ Date of diagnosis: _____

☐ Implanted automatic implantable cardioverter defibrillator (AICD)
ICD code: _____ Date of diagnosis: _____

☐ Infectious heart conditions (including active valvular infection, rheumatic heart disease, endocarditis, pericarditis or syphilitic heart disease)
ICD code: _____ Date of diagnosis: _____

☐ Pericardial adhesions ICD code: _____ Date of diagnosis: _____

☐ Other heart condition, specify below

Other diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____

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

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

2. Medical History

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

b. Do any of the Veteran's heart conditions qualify within the generally accepted medical definition of ischemic heart disease (IHD)?
☐ Yes ☐ No
If yes, list the conditions that qualify: _____

c. Provide the etiology, if known, of each of the Veteran's heart conditions, including the relationship/causality to other heart conditions, particularly the relationship/causality to the Veteran's IHD conditions, if any:

Heart condition #1: Provide etiology _____

Heart condition #2: Provide etiology _____

If there are additional heart conditions, list and provide etiology, using above format:
_____

d. Is continuous medication required for control of the Veteran's heart condition?
☐ Yes ☐ No
If yes, list medications required for the Veteran's heart condition (include name of medication and heart condition it is used for, such as atenolol for myocardial infarction or atrial fibrillation): _____
_____+-

3. Myocardial infarction (MI)

Has the Veteran had a myocardial infarction (MI)?
☐ Yes ☐ No
If yes, complete the following:

MI #1: Date and treatment facility: _____
MI #2: Date and treatment facility: _____
If the Veteran has had additional MIs, list using above format: _____

4. Congestive Heart Failure (CHF)

Has the Veteran had congestive heart failure (CHF)?
☐ Yes ☐ No
If yes, complete the following:

a. Does the Veteran have chronic CHF?
☐ Yes ☐ No

b. Has the Veteran had any episodes of acute CHF in the past year?
☐ Yes ☐ No
If yes, complete the following:
Specify number of episodes of acute CHF the Veteran has had in the past year:
☐ 0 ☐ 1 ☐ More than 1
Provide date of most recent episode of acute CHF: _____
Was the Veteran admitted for treatment of acute CHF?
☐ Yes ☐ No
If, yes, indicate name of treatment facility: _____

5. Arrhythmia

Has the Veteran had a cardiac arrhythmia?
☐ Yes ☐ No
If yes, complete the following:

Type of arrhythmia (check all that apply):

☐ Atrial fibrillation
If checked, indicate frequency: ☐ Constant ☐ Intermittent (paroxysmal)
If intermittent, indicate number of episodes in the past 12 months: ☐ 0 ☐ 1-4 ☐ More than 4
Indicate how these episodes were documented (check all that apply)
☐ EKG ☐ Holter ☐ Other, specify: _____

☐ Atrial flutter
If checked, indicate frequency:
If checked, indicate frequency: ☐ Constant ☐ Intermittent (paroxysmal)
If intermittent, indicate number of episodes in the past 12 months: ☐ 0 ☐ 1-4 ☐ More than 4
Indicate how these episodes were documented (check all that apply)
☐ EKG ☐ Holter ☐ Other, specify: _____

☐ Supraventricular tachycardia
If checked, indicate frequency: ☐ Constant ☐ Intermittent (paroxysmal)
If intermittent, indicate number of episodes in the past 12 months: ☐ 0 ☐ 1-4 ☐ More than 4
Indicate how these episodes were documented (check all that apply)
☐ EKG ☐ Holter ☐ Other, specify: _____

☐ Atrioventricular block
☐ I degree ☐ II degree ☐ III degree

☐ Ventricular arrhythmia (sustained)
Indicate date of hospital admission for initial evaluation and medical treatment in the Procedures section below

☐ Other cardiac arrhythmia, specify: _____
If checked, indicate frequency: ☐ Constant ☐ Intermittent (paroxysmal)
If intermittent, indicate number of episodes in the past 12 months: ☐ 0 ☐ 1-3 ☐ More than 4
Indicate how these episodes were documented (check all that apply)
☐ EKG ☐ Holter ☐ Other, specify: _____

6. Heart valve conditions

Has the Veteran had a heart valve condition?
☐ Yes ☐ No
If yes, complete the following:

a. Valves affected (check all that apply):
☐ Mitral ☐ Tricuspid ☐ Aortic ☐ Pulmonary

b. Describe type of valve condition for each checked valve: _____

7. Infectious heart conditions

Has the Veteran had any infectious cardiac conditions, including active valvular infection (including rheumatic heart disease), endocarditis, pericarditis or syphilitic heart disease?
☐ Yes ☐ No
If yes, complete the following:

a. Has the Veteran undergone or is the Veteran currently undergoing treatment for an active infection?
☐ Yes ☐ No
If yes, describe treatment and site of infection being treated: _____
Has treatment for an active infection been completed?
☐ Yes ☐ No
Date completed: _____

b. Has the Veteran had a syphilitic aortic aneurysm?
☐ Yes ☐ No
If yes, ALSO complete Artery and Vein Conditions Questionnaire.

8. Pericardial adhesions

Has the Veteran had pericardial adhesions?

☐ Yes ☐ No

If yes, complete the following:

Etiology of pericardial adhesions: ☐ Pericarditis ☐ Cardiac surgery/bypass ☐ Other, describe: __

9. Procedures

Has the Veteran had any non-surgical or surgical procedures for the treatment of a heart condition?

☐ Yes ☐ No

If yes, indicate the non-surgical or surgical procedures the Veteran has had for the treatment of heart conditions (check all that apply):

- ☐ Percutaneous coronary intervention (PCI) (angioplasty)
  - Indicate date of treatment or date of admission if admitted for treatment and treatment facility: _____
- ☐ Coronary artery bypass surgery
  - Indicate date of admission for treatment and treatment facility: _____
- ☐ Heart valve replacement
  - Specify valve(s) replaced and type of valve(s): _____
  - Indicate date of admission for treatment and treatment facility: _____
- ☐ Heart transplant:
  - Indicate date of admission for treatment and treatment facility: _____
- ☐ Implanted cardiac pacemaker
  - Indicate date of admission for treatment and treatment facility: _____
- ☐ Implanted automatic implantable cardioverter defibrillator (AICD)
  - Indicate date of admission for treatment and treatment facility: _____
- ☐ Valve replacement

  If checked, indicate valve(s) that have been replaced (check all that apply):
  - ☐ Mitral ☐ Tricuspid ☐ Aortic ☐ Pulmonary
  - Indicate date of admission for treatment and treatment facility for each checked valve: _____
- ☐ Ventricular aneurysmectomy
  - Indicate date of admission for treatment and treatment facility: _____
- ☐ Other surgical and/or non-surgical procedures for the treatment of a heart condition, describe: _____
  - Indicate date of admission for treatment and treatment facility: _____
  - Indicate the condition that resulted in the need for this procedure/treatment: _____

10. Hospitalizations

Has the Veteran had any other hospitalizations for the treatment of heart conditions (other than for non-surgical and surgical procedures described above)?

☐ Yes ☐ No

If yes, complete the following:

a. Date of admission for treatment and treatment facility: _____

b. Condition that resulted in the need for hospitalization: _____

11. Physical exam

a. Heart rate: _____

b. Rhythm: ☐ Regular ☐ Irregular

c. Point of maximal impact: ☐ Not palpable ☐ 4th intercostal space ☐ 5th intercostal space ☐ Other, specify: _____

d. Heart sounds: ☐ Normal ☐ Abnormal, specify: _____

e. Jugular-venous distension: ☐ Yes ☐ No

f. Auscultation of the lungs ☐ Clear ☐ Bibasilar rales ☐ Other, describe: _____

g. Peripheral pulses:

Dorsalis pedis: ☐ Normal ☐ Diminished ☐ Absent

Posterior tibial: ☐ Normal ☐ Diminished ☐ Absent

h. Peripheral edema:

Right lower extremity: ☐ None ☐ Trace ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+

Left lower extremity: ☐ None ☐ Trace ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+

i. Blood pressure: _____

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. Diagnostic Testing

For VA purposes, exams for all heart conditions require a determination of whether or not cardiac hypertrophy or dilatation is present. The suggested order of testing for cardiac hypertrophy/dilatation is EKG, then chest x -ray (PA and lateral), then echocardiogram. An echocardiogram to determine heart size is only necessary if the other two tests are negative.

For VA purposes, if LVEF testing is not of record, but available medical information sufficiently reflects the severity of the Veteran's cardiovascular condition, LVEF testing is not required.

a. Is there evidence of cardiac hypertrophy?

☐ Yes ☐ No

If yes, indicate how this condition was documented: ☐ EKG ☐ Chest x-ray ☐ Echocardiogram

Date of test: _____

b. Is there evidence of cardiac dilatation?
☐ Yes ☐ No
If yes, indicate how this condition was documented: ☐ Chest x-ray ☐ Echocardiogram
Date of test: _____

c. Diagnostic tests
Indicate all testing completed; provide only most recent results which reflect the Veterans current functional status (check all that apply):

☐ EKG Date of EKG: _____
Result: ☐ Normal
☐ Arrhythmia, describe: _____
☐ Hypertrophy, describe: _____
☐ Ischemia, describe: _____
☐ Other, describe: _____

☐ Chest x-ray Date of CXR: _____
Result: ☐ Normal ☐ Abnormal, describe: _____

☐ Echocardiogram Date of echocardiogram: _____
Left ventricular ejection fraction (LVEF): _____%
Wall motion: ☐ Normal ☐ Abnormal, describe: _____
Wall thickness: ☐ Normal ☐ Abnormal, describe: _____

☐ Holter monitor Date of Holter monitor: _____
Result: ☐ Normal ☐ Abnormal, describe: _____

☐ MUGA Date of MUGA: _____
Left ventricular ejection fraction (LVEF): _____%
Result: ☐ Normal ☐ Abnormal, describe: _____

☐ Coronary artery angiogram Date of angiogram: _____
Result: ☐ Normal ☐ Abnormal, describe: _____

☐ CT angiography Date of CT angiography: _____
Result: ☐ Normal ☐ Abnormal, describe: _____

☐ Other test, specify: _____
Date: _____
Result: _____

14. METs Testing

NOTE: For VA purposes, all heart exams require METs testing (either exercise-based or interview-based) to determine the activity level at which symptoms such as dyspnea, fatigue, angina, dizziness, or syncope develop (except exams for supraventricular arrhythmias).

If a laboratory determination of METs by exercise testing cannot be done for medical reasons (e.g chronic CHF or multiple episodes of acute CHF within the past 12 months), or If exercise-based METs test was not completed because it is not required as part of the Veteran's treatment plan, or if exercise stress test results do not reflect Veteran's current cardiac function, perform an interview-based METs test based on the Veteran's responses to a cardiac activity questionnaire and provide the results below.

Indicate all testing completed; provide only most recent results which reflect the Veterans current functional status (check all that apply):

a. ☐ Exercise stress test
Date of most recent exercise stress test: _____
Results: _____
METs level the Veteran performed, if provided: _____

b. ☐ Interview-based METs test
Date of interview-based METs test: _____

Symptoms during activity:

The METs level checked below reflects the lowest activity level at which the Veteran reports any of the following symptoms (check all symptoms that the Veteran reports at the indicated METs level of activity):

☐ Dyspnea ☐ Fatigue ☐ Angina ☐ Dizziness ☐ Syncope ☐ Other, describe: _____

Results:

METs level on most recent interview-based METs test:

☐ (1-3 METs) This METs level has been found to be consistent with activities such as eating, dressing, taking a shower, slow walking (2 mph) for 1-2 blocks

☐ (>3-5 METs) This METs level has been found to be consistent with activities such as light yard work (weeding), mowing lawn (power mower), brisk walking (4 mph)

☐ (>5-7 METs) This METs level has been found to be consistent with activities such as walking 1 flight of stairs, golfing (without cart), mowing lawn (push mower), heavy yard work (digging)

☐ (>7-10 METs) This METs level has been found to be consistent with activities such as climbing stairs quickly, moderate bicycling, sawing wood, jogging (6 mph)

☐ The Veteran denies experiencing symptoms with any level of physical activity

c. If the Veteran has had both an exercise stress test and an interview-based METs test, indicate which results most accurately reflect the Veteran's current cardiac functional level:

☐ Exercise stress test ☐ Interview-based METs test ☐ N/A

d. Is the METs level limitation due solely to the heart condition(s)?

☐ Yes ☐ No

If no, estimate the percentage of the METs level limitation that is due solely to the heart condition(s):

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90%

☐ The limitation in METs level is due to multiple factors; it is not possible to accurately estimate this percentage

e. In addition to the heart condition(s), does the Veteran have other non-cardiac medical conditions (such as musculoskeletal or pulmonary conditions) limiting the METs level?

☐ Yes ☐ No

If yes, identify each condition and describe how each non-cardiac medical condition limits the Veteran's METs level:

Other medical condition #1: _____ Effect on METs level: _____

Other medical condition #2: _____ Effect on METs level: _____

If there are additional medical conditions affecting METs level, list using above format: _____

15. Functional impact

Does the Veteran's heart condition(s) impact his or her ability to work?

☐ Yes ☐ No

If yes, describe impact of each of the Veteran's heart 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 Hypertension

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 been diagnosed with hypertension or isolated systolic hypertension based on the following criteria:

NOTE 1: For VA disability rating purposes, the term hypertension means that the diastolic blood pressure is predominantly 90mm or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm or greater with a diastolic blood pressure of less than 90mm.

NOTE 2: For VA purposes, for the INITIAL diagnosis of hypertension or isolated systolic hypertension must be confirmed by readings taken 2 or more times on at least 3 different days. Blood pressure results may be obtained from existing medical records or through scheduled visits for blood pressure measurements.

☐ Yes ☐ No

If yes, provide only diagnoses that pertain to hypertension:

☐ Hypertension ICD code: _____ Date of diagnosis: _____
☐ Isolated systolic hypertension ICD code: _____ Date of diagnosis: _____
☐ Other, specify:
Other diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____

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

If there are additional diagnoses that pertain to hypertension or isolated systolic hypertension, list using above format: _____

NOTE 3: ALSO complete appropriate questionnaires for hypertension-related complications, if any(such as Kidney, if renal insufficiency attributable to hypertension).

2. Medical history

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

b. Does the Veteran's treatment plan include taking continuous medication for hypertension or isolated systolic hypertension?
☐ Yes ☐ No
If yes, list only those medications used for the diagnosed conditions: _____

c. Was the Veteran's initial diagnosis of hypertension or isolated systolic hypertension confirmed by blood pressure (BP) readings taken 2 or more times on at least 3 different days?
☐ Yes ☐ No ☐ Unknown

If yes, provide BP readings used to establish initial diagnosis, if known:

Reading 1: _____/_____ Reading 2: _____/_____ Date: _____
Reading 1: _____/_____ Reading 2: _____/_____ Date: _____
Reading 1: _____/_____ Reading 2: _____/_____ Date: _____

If no, report BP readings taken 2 or more times on at least 3 different days in order to confirm diagnosis (unless veteran is on treatment for hypertension).

Reading 1: _____/_____ Reading 2: _____/_____ Date: _____
Reading 1: _____/_____ Reading 2: _____/_____ Date: _____
Reading 1: _____/_____ Reading 2: _____/_____ Date: _____

d. Does the Veteran have a history of a diastolic BP elevation to predominantly 100 or more?

☐ Yes ☐ No

If yes, describe frequency and severity of diastolic BP elevation: _____

3. Current blood pressure readings (sufficient if Veteran has a previously established diagnosis of hypertension).

Blood pressure reading 1: _____/_____ Date: _____
Blood pressure reading 2: _____/_____ Date: _____
Blood pressure reading 3: _____/_____ Date: _____

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 condition listed in the Diagnosis section above?

☐ Yes ☐ No

If yes, describe (brief summary): _____

5. Functional impact

Does the Veteran's hypertension or isolated systolic hypertension impact his or her ability to work?

☐ Yes ☐ No

If yes, describe the impact of the Veteran's hypertension or isolated systolic hypertension, 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.

6.7. DBQ Knee and Lower Leg 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 knee and/or lower leg condition?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to knee and/or lower leg 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 knee and/or lower leg conditions, list using above format: ____

2. Medical history

a. Describe the history (including onset and course) of the Veteran's knee and/or lower leg condition (brief summary): _____

3. Flare-ups

Does the Veteran report that flare-ups impact the function of the knee and/or lower leg?
☐ 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 knee flexion

Select where flexion ends (normal endpoint is 140 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 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 or greater

b. Right knee extension

Select where extension ends:

☐ 0 or any degree of hyperextension (check this box if there is no limitation of extension)
Unable to fully extend; extension ends at:
☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 or greater

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐ 0 or any degree of hyperextension (check this box if there is no limitation of extension)
Unable to fully extend; extension ends at:
☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 or greater

c. Left knee flexion

Select where flexion ends (normal endpoint is 140 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 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 or greater

d. Left knee extension

Select where extension ends:

☐ 0 or any degree of hyperextension (check this box if there is no limitation of extension)
Unable to fully extend; extension ends at:
☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 or greater

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐ 0 or any degree of hyperextension (check this box if there is no limitation of extension)
Unable to fully extend; extension ends at:
☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 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 knee and/or leg 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 knee 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 or greater

Select where post-test extension ends:
☐ 0 or any degree of hyperextension (check this box if there is no limitation of extension)
Unable to fully extend; extension ends at:
☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 or greater

c. Left knee 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 or greater

Select where post-test extension ends:
☐ 0 or any degree of hyperextension (check this box if there is no limitation of extension)
Unable to fully extend; extension ends at:
☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 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 knee and lower leg following repetitive-use testing?
☐ Yes ☐ No

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

c. If the Veteran has functional loss, functional impairment or additional limitation of ROM of the knee and lower leg 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 ☐ Right ☐ Left ☐ Both

and weight-bearing
☐ Other, describe: _____

7. Pain (pain on palpation)

Does the Veteran have tenderness or pain to palpation for joint line or soft tissues of either knee?

☐ 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

Knee 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
Knee 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. Joint stability tests

a. Anterior instability (Lachman test):

☐ Unable to test: ☐ Right ☐ Left ☐ Both

Right: ☐ Normal ☐ 1+ (0-5 millimeters) ☐ 2+ (5-10 millimeters) ☐ 3+ (10-15 millimeters)
Left: ☐ Normal ☐ 1+ (0-5 millimeters) ☐ 2+ (5-10 millimeters) ☐ 3+ (10-15 millimeters)

b. Posterior instability (Posterior drawer test):

☐ Unable to test: ☐ Right ☐ Left ☐ Both

Right: ☐ Normal ☐ 1+ (0-5 millimeters) ☐ 2+ (5-10 millimeters) ☐ 3+ (10-15 millimeters)
Left: ☐ Normal ☐ 1+ (0-5 millimeters) ☐ 2+ (5-10 millimeters) ☐ 3+ (10-15 millimeters)

c. Medial-lateral instability (Apply valgus/varus pressure to knee in extension and 30 degrees of flexion):

☐ Unable to test: ☐ Right ☐ Left ☐ Both

Right: ☐ Normal ☐ 1+ (0-5 millimeters) ☐ 2+ (5-10 millimeters) ☐ 3+ (10-15 millimeters)
Left: ☐ Normal ☐ 1+ (0-5 millimeters) ☐ 2+ (5-10 millimeters) ☐ 3+ (10-15 millimeters)

10. Patellar subluxation/dislocation

Is there evidence or history of recurrent patellar subluxation/dislocation?

☐ Yes ☐ No

If yes, indicate severity and side affected:

Right: ☐ None ☐ Slight ☐ Moderate ☐ Severe
Left: ☐ None ☐ Slight ☐ Moderate ☐ Severe

11. Additional conditions

Does the Veteran now have or has he or she ever had "shin splints" (medial tibial stress syndrome), stress fractures, chronic exertional compartment syndrome or any other tibial and/or fibular impairment?
☐ Yes ☐ No
If yes, indicate condition and complete the appropriate sections below.

a. ☐ "Shin splints" (medial tibial stress syndrome)
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both
Describe current symptoms: _____

b. ☐Stress fracture of the lower extremity
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both
Describe current symptoms: _____

c. ☐ Chronic exertional compartment syndrome
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both
Describe current symptoms: _____

d. ☐ Evidence of acquired, traumatic genu recurvatum with weakness and insecurity in weight-bearing
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both

e. ☐ 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

12. Meniscal conditions and meniscal surgery

Has the Veteran had any meniscal conditions or surgical procedures for a meniscal condition?
☐ Yes ☐ No
If yes, complete the following section:

a. Does the Veteran now have or has he or she ever had a meniscus (semilunar cartilage) condition?
☐ Yes ☐ No
If yes, indicate severity and frequency of symptoms, and side affected:

☐ No symptoms	☐ Right	☐ Left	☐ Both
☐ Meniscal dislocation	☐ Right	☐ Left	☐ Both
☐ Meniscal tear	☐ Right	☐ Left	☐ Both
☐ Frequent episodes of joint "locking"	☐ Right	☐ Left	☐ Both
☐ Frequent episodes of joint pain	☐ Right	☐ Left	☐ Both
☐ Frequent episodes of joint effusion	☐ Right	☐ Left	☐ Both

b. Has the Veteran had a meniscectomy?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both
Date of surgery: _____

c. Does the Veteran have any residual signs and/or symptoms due to a meniscectomy?
☐ Yes ☐ No
If yes, indicate side affected: ☐ Right ☐ Left ☐ Both
Describe residuals: _____

13. Joint replacement and other surgical procedures

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

☐ Yes ☐ No

If yes, indicate side and severity of residuals.

☐ Right knee

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: _____

☐ Left knee

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 knee surgery not described above?

☐ 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 knee surgery not described above?

☐ Yes ☐ No

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

Describe residuals: _____

14. 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): _____

15. 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
☐ Crutches(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: _____

16. Remaining effective function of the extremities

Due to the Veteran's knee and/or lower leg 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 extremity(ies) 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): _____

17. 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 knee been performed and are the results available?
☐ Yes ☐ No
If yes, is degenerative or traumatic arthritis documented?
☐ Yes ☐ No
If yes, indicate knee: ☐ Right ☐ Left ☐ Both

b. Does the Veteran have x-ray evidence of patellar subluxation?
☐ Yes ☐ No
If yes, indicate affected side(s): ☐ Right ☐ Left ☐ Both

c. 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): _____

18. Functional impact

Does the Veteran's knee and/or lower leg condition(s) impact his or her ability to work?

☐ Yes ☐ No

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

19. 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 Medical Opinion

Name of 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. Definitions

Aggravation of preexisting nonservice-connected disabilities. A preexisting injury or disease will be considered to have been aggravated by active military, naval, or air service, where there is an increase in disability during such service, unless there is a specific finding that the increase in disability is due to the natural progress of the disease.

Aggravation of nonservice-connected disabilities. Any increase in severity of a nonservice-connected disease or injury that is proximately due to or the result of a service-connected disease or injury, and not due to the natural progress of the nonservice-connected disease, will be service connected.

2. Restatement of requested opinion

a. Insert requested opinion from general remarks: _____

b. Indicate type of exam for which opinion has been requested (e.g. Skin Diseases): _____

3. Evidence review

Was the Veteran's VA claims file reviewed?

☐ Yes ☐ No

If yes, list any records that were reviewed but were not included in the Veteran's VA claims file:

_____

If no, check all records reviewed:

- ☐ Military service treatment records
- ☐ Military service personnel records
- ☐ Military enlistment examination
- ☐ Military separation examination
- ☐ Military post-deployment questionnaire
- ☐ Department of Defense Form 214 Separation Documents
- ☐ Veterans Health Administration medical records (VA treatment records)
- ☐ Civilian medical records
- ☐ Interviews with collateral witnesses (family and others who have known the veteran before and after military service)
- ☐ No records were reviewed
- ☐ Other: _____

Complete only the sections below that you are asked to complete in the Medical Opinion DBQ request.

4. Medical opinion for direct service connection

Choose the statement that most closely approximates the etiology of the claimed condition.

a. ☐ The claimed condition was at least as likely as not (50 percent or greater probability) incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section c.

b. ☐ The claimed condition was less likely than not (less than 50 percent probability) incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section c.

c. Rationale:

_____
_____
_____
_____

5. Medical opinion for secondary service connection

a. ☐ The claimed condition is at least as likely as not (50 percent or greater probability) proximately due to or the result of the Veteran's service connected condition. Provide rationale in section c.

b. ☐ The claimed condition is less likely than not (less than 50 percent probability) proximately due to or the result of the Veteran's service connected condition. Provide rationale in section c.

c. Rationale:

_____
_____
_____
_____

6. Medical opinion for aggravation of a condition that existed prior to service

a. ☐ The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section c.

b. ☐ The claimed condition, which clearly and unmistakably existed prior to service, was clearly and unmistakably not aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section c.

c. Rationale:

_____
_____
_____
_____

7. Medical opinion for aggravation of a nonservice connected condition by a service connected condition

a. Can you determine a baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition)?
☐ Yes ☐ No

If "Yes" to question 7a, answer the following:

i. Describe the baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition):
_____
_____

ii. Provide the date and nature of the medical evidence used to provide the baseline: _____

iii. Is the current severity of the (claimed condition/diagnosis) greater than the baseline?
☐ Yes ☐ No

If yes, was the Veteran's (claimed condition/diagnosis) at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?
☐ Yes (provide rationale in section b.)
☐ No (provide rationale in section b.)

If "No" to question 7a, answer the following:

i. Provide rationale as to why a baseline cannot be established (e.g. medical evidence is not sufficient to support a determination of a baseline level of severity): _____

ii. Regardless of an established baseline, was the Veteran's (claimed condition/diagnosis) at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?
☐ Yes (provide rationale in section b.)
☐ No (provide rationale in section b.)

b. Provide rationale:
_____
_____
_____
_____

8. Opinion regarding conflicting medical evidence

I have reviewed the conflicting medical evidence and am providing the following opinion:

_____
_____
_____

Physician signature: _____ Date: _____

Physician printed name: _____ Phone: _____

Medical license #: _____ Physician address: _____

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 Scars Disfigurement

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

a. Does the Veteran have one or more scars anywhere on the body, or disfigurement of the head, face, or neck?

☐ Yes ☐ No

If yes, provide only diagnoses that pertain to scars anywhere on the body, or disfigurement of the head, face or neck:

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 scars anywhere on the body, or disfigurement of the head, face, or neck due to scars or other causes, list using above format: _____

b. Does the Veteran have any scars on the trunk or extremities (regions other than the head, face or neck)?

☐ Yes ☐ No

If yes, complete Section I

c. Does the Veteran have any scars or disfigurement of the head, face or neck?

☐ Yes ☐ No

If yes, complete Section II

INSTRUCTIONS:
Provide all linear measurements in centimeters and area measurements in centimeters squared.
For non-linear scars, measure the length and width at their widest points.
After measuring the scars, use the summary sections to provide the combined approximate total area for all scars in each region.
If scars are too numerous to count (for example, multiple scattered shrapnel wound scars, acne scarring or pseudofolliculitis barbae), indicate "TNTC" and provide approximate combined total area.

Regardless of the answers to questions 1b and 1c, complete Section III.

NOTE: For VA purposes, superficial non-linear scars are those not associated with underlying soft tissue damage, while deep non-linear scars are associated with underlying soft tissue damage.

SECTION I: Scars of the trunk and extremities

1. Medical history

a. Describe the history (including cause/origin and course) of the Veteran's scar(s) of the trunk or extremities, (brief summary): _____

b. Are any of the scars of the trunk or extremities painful?

☐ Yes ☐ No

If yes, specify number of painful scars: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Describe the pain (if there are multiple painful scars, be sure to adequately identify which scars are painful): _____

c. Are any of the scars of the trunk or extremities unstable, with frequent loss of covering of skin over the scar?

☐ Yes ☐ No

If yes, specify number of unstable scars: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Describe the loss of covering of skin over the scar (if there are multiple unstable scars, be sure to adequately identify which scars are unstable): _____

d. Are any of the scars BOTH painful and unstable?

☐ Yes ☐ No

If yes, specify number of scars that are both painful and unstable: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Describe location of these scars; _____

e. Are any of the scars of the trunk or extremities due to burns?

☐ Yes ☐ No

If yes, identify each burn scar and state depth of original burn:

Burn Scar #1: _____

- ☐ Full thickness or sub-dermal
- ☐ Deep partial thickness
- ☐ Less than deep partial thickness

Burn Scar #2: _____

- ☐ Full thickness or sub-dermal
- ☐ Deep partial thickness
- ☐ Less than deep partial thickness

If there are additional burn scars of the trunk and extremities, list using the above format: _____

2. Physical exam for scars on the trunk and extremities

2-1. Details of scar findings for the trunk and extremities

Indicate the anatomical regions affected and complete appropriate sections:

a. Right upper extremity

☐ Affected ☐ Not affected

Specify location of scars on right upper extremity and number them: _____

Indicate types of scars and provide measurements (check all that apply):

☐ Linear

Length of each linear scar:

Scar #1: __ cm Scar #2: __ cm Scar #3: __ cm Scar #4: __ cm

Scar #5: __ cm If additional scars, list using same format: _____

☐ Superficial non-linear

Length and width of each superficial non-linear scar:

Scar #1: __x__cm Scar #2: __x__cm Scar #3: __x__cm Scar #4: __x__cm

Scar #5: __x__cm If additional scars, list using same format: _____

☐ Deep non-linear

Length and width of each deep non-linear scar:

Scar #1: __x__cm Scar #2: __x__cm Scar #3: __x__cm Scar #4: __x__cm
Scar #5: __x__cm If additional scars, list using same format: _____

b. Left upper extremity

☐ Affected ☐ Not affected

Specify location of scars on left upper extremity and number them: _____

Indicate types of scars and provide measurements (check all that apply):

☐ Linear

Length of each linear scar:
Scar #1: __ cm Scar #2: __ cm Scar #3: __ cm Scar #4: __ cm
Scar #5: __ cm If additional scars, list using same format: _____

☐ Superficial non-linear

Length and width of each superficial non-linear scar:
Scar #1: __x__cm Scar #2: __x__cm Scar #3: __x__cm Scar #4: __x__cm
Scar #5: __x__cm If additional scars, list using same format: _____

☐ Deep non-linear

Length and width of each deep non-linear scar:
Scar #1: __x__cm Scar #2: __x__cm Scar #3: __x__cm Scar #4: __x__cm
Scar #5: __x__cm If additional scars, list using same format: _____

c. Right lower extremity

☐ Affected ☐ Not affected

Specify location of scars on right lower extremity and number them: _____

Indicate types of scars and provide measurements (check all that apply):

☐ Linear

Length of each linear scar:
Scar #1: __ cm Scar #2: __ cm Scar #3: __ cm Scar #4: __ cm
Scar #5: __ cm If additional scars, list using same format: _____

☐ Superficial non-linear

Length and width of each superficial non-linear scar:
Scar #1: __x__cm Scar #2: __x__cm Scar #3: __x__cm Scar #4: __x__cm
Scar #5: __x__cm If additional scars, list using same format: _____

☐ Deep non-linear

Length and width of each deep non-linear scar:
Scar #1: __x__cm Scar #2: __x__cm Scar #3: __x__cm Scar #4: __x__cm
Scar #5: __x__cm If additional scars, list using same format: _____

d. Left lower extremity

☐ Affected ☐ Not affected

Specify location of scars on left lower extremity and number them: _____

Indicate types of scars and provide measurements (check all that apply):

☐ Linear

Length of each linear scar:
Scar #1: __ cm Scar #2: __ cm Scar #3: __ cm Scar #4: __ cm
Scar #5: __ cm If additional scars, list using same format: _____

☐ Superficial non-linear

Length and width of each superficial non-linear scar:
Scar #1: __x__cm Scar #2: __x__cm Scar #3: __x__cm Scar #4: __x__cm
Scar #5: __x__cm If additional scars, list using same format: _____

☐ Deep non-linear

Length and width of each deep non-linear scar:
Scar #1: __x__cm Scar #2: __x__cm Scar #3: __x__cm Scar #4: __x__cm
Scar #5: __x__cm If additional scars, list using same format: _____

e. Anterior trunk

☐ Affected ☐ Not affected

Specify location of scars on anterior trunk and number them: _____

Indicate types of scars and provide measurements (check all that apply):

☐ Linear

Length of each linear scar:

Scar #1: __ cm Scar #2: __ cm Scar #3: __ cm Scar #4: __ cm
Scar #5: __ cm If additional scars, list using same format: _____

☐ Superficial non-linear
Length and width of each superficial non-linear scar:
Scar #1: __x__cm Scar #2: __x__cm Scar #3: __x__cm Scar #4: __x__cm
Scar #5: __x__cm If additional scars, list using same format: _____

☐ Deep non-linear
Length and width of each deep non-linear scar:
Scar #1: __x__cm Scar #2: __x__cm Scar #3: __x__cm Scar #4: __x__cm
Scar #5: __x__cm If additional scars, list using same format: _____

f. Posterior trunk

☐ Affected ☐ Not affected

Specify location of scars on posterior trunk and number them: _____

Indicate types of scars and provide measurements (check all that apply):

☐ Linear
Length of each linear scar:
Scar #1: __cm Scar #2: __cm Scar #3: __cm Scar #4: __cm
Scar #5: __cm If additional scars, list using same format: _____

☐ Superficial non-linear
Length and width of each superficial non-linear scar:
Scar #1: __x__cm Scar #2: __x__cm Scar #3: __x__cm Scar #4: __x__cm
Scar #5: __x__cm If additional scars, list using same format: _____

☐ Deep non-linear
Length and width of each deep non-linear scar:
Scar #1: __x__cm Scar #2: __x__cm Scar #3: __x__cm Scar #4: __x__cm
Scar #5: __x__cm If additional scars, list using same format: _____

2-2. Summary of nonlinear scar areas for the trunk and extremities

a. Superficial non-linear scars (check all that apply and provide approximate combined total area in centimeters squared for each affected anatomical region)

☐ None
☐ Right upper extremity: Approximate total area: _____ cm2
☐ Left upper extremity: Approximate total area: _____ cm2
☐ Right lower extremity: Approximate total area: _____ cm2
☐ Left lower extremity: Approximate total area: _____ cm2
☐ Anterior trunk: Approximate total area: _____ cm2
☐ Posterior trunk: Approximate total area: _____ cm2

b. Deep non-linear scars (check all that apply and provide approximate combined total area in centimeters squared for each affected anatomical region)

☐ None
☐ Right upper extremity: Approximate total area: _____ cm2
☐ Left upper extremity: Approximate total area: _____ cm2
☐ Right lower extremity: Approximate total area: _____ cm2
☐ Left lower extremity: Approximate total area: _____ cm2
☐ Anterior trunk: Approximate total area: _____ cm2
☐ Posterior trunk: Approximate total area: _____ cm2

SECTION II: Scars or other disfigurement of the head, face or neck)

1. Medical history

a. Describe the history (including cause/origin and course) of the Veteran's scar(s) or other disfigurement of the head, face, or neck (brief summary): _____

b. Are any of the scars of the head, face, or neck painful?

☐ Yes ☐ No

If yes, specify number of painful scars: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Describe the pain (if there are multiple painful scars, be sure to adequately identify which scars are painful): _____

c. Are any of the scars of the head, face, or neck unstable, with frequent loss of covering of skin over the scar?

☐ Yes ☐ No

If yes, specify number of unstable scars: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Describe the loss of covering of skin over the scar (if there are multiple unstable scars, be sure to adequately identify which scars are unstable): _____

d. Are any of the scars of the head face or neck BOTH painful and unstable?

☐ Yes ☐ No

If yes, specify number of scars that are both painful and unstable: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Describe location of these scars; _____

e. Are any of the scars of the head, face, or neck due to burns?

☐ Yes ☐ No

If yes, identify each burn scar and state depth of original burn:

Burn Scar #1: _____

☐ Full thickness or sub-dermal
☐ Deep partial thickness
☐ Less than deep partial thickness

Burn Scar #2: _____

☐ Full thickness or sub-dermal
☐ Deep partial thickness
☐ Less than deep partial thickness

If there are additional burn scars of the head, face, or neck, list using the above format: _____

2. Physical exam for scars or disfigurement of the head, face and neck

2-1. Details of scar or disfigurement for the head, face, and neck

a. Identify each scar or disfigurement and provide measurements:

Scar/Disfigurement #1

Indicate type of impairment: ☐ Scar ☐ Disfigurement

Location of scar/disfigurement #1: _____

Length and width (at widest part) of scar/disfigurement #1: __x__ cm

Scar/Disfigurement #2

Indicate type of impairment: ☐ Scar ☐ Disfigurement

Location of scar/disfigurement #2: _____

Length and width (at widest part) of scar/disfigurement #2: __x__ cm

Scar/Disfigurement #3

Indicate type of impairment: ☐ Scar ☐ Disfigurement

Location of scar/disfigurement #3: _____
Length and width (at widest part) of scar/disfigurement #3: __x__ cm

Scar/Disfigurement #4
Indicate type of impairment: ☐ Scar ☐ Disfigurement

Location of scar/disfigurement #4: _____
Length and width (at widest part) of scar/disfigurement #4: __x__ cm

Scar/Disfigurement #5
Indicate type of impairment: ☐ Scar ☐ Disfigurement

Location of scar/disfigurement #5: _____
Length and width (at widest part) of scar/disfigurement #5: __x__ cm

If additional scars or disfigurement, list using same format: _____

b. Is there elevation, depression, adherence to underlying tissue, or missing underlying soft tissue?
☐ Yes ☐ No
If yes, check all that apply:

- ☐ Surface contour elevated on palpation
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1 ☐ Scar/Disfigurement #2 ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4 ☐ Scar/Disfigurement #5 ☐ Other: _____
- ☐ Surface contour depressed on palpation
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1 ☐ Scar/Disfigurement #2 ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4 ☐ Scar/Disfigurement #5 ☐ Other: _____
- ☐ Scar adherent to underlying tissue
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1 ☐ Scar/Disfigurement #2 ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4 ☐ Scar/Disfigurement #5 ☐ Other: _____
- ☐ Underlying soft tissue missing
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1 ☐ Scar/Disfigurement #2 ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4 ☐ Scar/Disfigurement #5 ☐ Other: _____

c. Is there abnormal pigmentation or texture of the head, face, or neck?
☐ Yes ☐ No
If yes, check all that apply:

- ☐ Hypopigmentation
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1 ☐ Scar/Disfigurement #2 ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4 ☐ Scar/Disfigurement #5 ☐ Other: _____
- ☐ Hyperpigmentation
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1 ☐ Scar/Disfigurement #2 ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4 ☐ Scar/Disfigurement #5 ☐ Other: _____
- ☐ Induration and inflexibility
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1 ☐ Scar/Disfigurement #2 ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4 ☐ Scar/Disfigurement #5 ☐ Other: _____
- ☐ Abnormal texture
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1 ☐ Scar/Disfigurement #2 ☐ Scar/Disfigurement #3

☐ Scar/Disfigurement #4 ☐ Scar/Disfigurement #5 ☐ Other: _____
Describe type of abnormal texture (for example, irregular, atrophic, shiny or scaly):
_____

2-2. Summary of scars or other disfigurement of the head, face and neck

Provide approximate combined total area in centimeters squared for each characteristic of disfigurement:

a. Approximate total area of head, face and neck with hypo- or hyperpigmented areas: _____ cm2
b. Approximate total area of head, face and neck with abnormal texture: ____ cm2
c. Approximate total area of head, face and neck with missing underlying soft tissue: _____ cm2
d. Approximate total area of head, face and neck that is indurated and inflexible: _____ cm2

2-3. Distortion of facial features and tissue loss for the head, face and neck

Is there gross distortion or asymmetry of facial features or visible or palpable tissue loss?
☐ Yes ☐ No
If yes, indicate features affected (check all that apply):
☐ Nose ☐ Chin ☐ Forehead ☐ Cheeks ☐ Lips
☐ Eyes (including eyelids)
If checked, specify:
☐ Tissue loss/distortion of eyelid Side: ☐ Right ☐ Left
☐ Tissue loss/distortion of eye Side: ☐ Right ☐ Left
☐ Anatomical loss of eye Side: ☐ Right ☐ Left
☐ Ears (auricles)
If checked, specify:
☐ Complete loss of auricle Side: ☐ Right ☐ Left
☐ Deformity of auricle, with loss of less than one-third the substance Side: ☐ Right ☐ Left
☐ Deformity of auricle, with loss of one-third or more of the substance Side: ☐ Right ☐ Left

For all checked features, provide brief description of the tissue loss, gross distortion and/or asymmetry of facial features: _____

SECTION III: Miscellaneous

Complete this section for all scars or disfigurements, regardless of location.

1. Limitation of function/other conditions

a. Do any of the scars (regardless of location) or disfigurement of the head, face, or neck result in limitation of function?
☐ Yes ☐ No
If yes, indicate which scars (regardless of location) or disfigurement of the head, face, or neck are causing the limitation and describe the specific limitations: _____

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms (such as muscle or nerve damage) associated with any scar (regardless of location) or disfigurement of the head, face, or neck?
☐ Yes ☐ No
If yes, describe (brief summary): _____

2. Color photographs

Provide color photographs, if possible, for any disfiguring conditions of the head, face and/or neck.
☐ Photographs not indicated ☐ Photographs provided ☐ Photographs not available

3. Functional impact

Does the Veteran's scar(s) (regardless of location) or disfigurement of the head, face, or neck impact his or her ability to work?

☐ Yes ☐ No
If yes, describe impact of the Veteran's scar(s) (regardless of location) or disfigurement of the head, face, or neck, providing one or more examples: _____

4. 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 Shoulder and Arm 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 shoulder and/or arm condition?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to shoulder and/or arm 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 shoulder and/or arm conditions, list using above format: ___

2. Medical history

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

b. Dominant hand:
☐ Right ☐ Left ☐ Ambidextrous

3. Flare-ups

Does the Veteran report that flare-ups impact the function of the shoulder and/or arm?
☐ 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 shoulder flexion

Select where flexion ends (normal endpoint is 180 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 ☐150 ☐155 ☐160 ☐165 ☐170 ☐175 ☐180

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 ☐150 ☐155 ☐160 ☐165 ☐170 ☐175 ☐180

b. Right shoulder abduction

Select where abduction ends (normal endpoint is 180 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 ☐150 ☐155 ☐160 ☐165 ☐170 ☐175 ☐180

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 ☐150 ☐155 ☐160 ☐165 ☐170 ☐175 ☐180

c. Left shoulder flexion

Select where flexion ends (normal endpoint is 180 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 ☐150 ☐155 ☐160 ☐165 ☐170 ☐175 ☐180

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 ☐150 ☐155 ☐160 ☐165 ☐170 ☐175 ☐180

d. Left shoulder abduction

Select where abduction ends (normal endpoint is 180 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 ☐150 ☐155 ☐160 ☐165 ☐170 ☐175 ☐180

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 ☐150 ☐155 ☐160 ☐165 ☐170 ☐175 ☐180

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 shoulder or arm 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 shoulder post-test ROM

Select where 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 ☐150 ☐155 ☐160 ☐165 ☐170 ☐175 ☐180

Select where abduction 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 ☐150 ☐155 ☐160 ☐165 ☐170 ☐175 ☐180

c. Left shoulder post-test ROM

Select where 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 ☐150 ☐155 ☐160 ☐165 ☐170 ☐175 ☐180

Select where abduction 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 ☐150 ☐155 ☐160 ☐165 ☐170 ☐175 ☐180

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 shoulder and arm following repetitive-use testing?

☐ Yes ☐ No

b. Does the Veteran have any functional loss and/or functional impairment of the shoulder and arm?

☐ Yes ☐ No

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

a. Does the Veteran have localized tenderness or pain on palpation of joints/soft tissue/biceps tendon of either shoulder?

☐ Yes ☐ No

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

b. Does the Veteran have guarding of either shoulder?

☐ Yes ☐ No

If yes, shoulder 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

Shoulder 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
Shoulder forward 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

9. Ankylosis

Does the Veteran have ankylosis of the glenohumeral articulation (shoulder joint)?

☐ Yes ☐ No

If yes, indicate severity and side affected:

☐ Abduction to 60 degrees; can reach mouth and head ☐ Right ☐ Left ☐ Both
☐ Abduction limited to between 60 and 25 degrees ☐ Right ☐ Left ☐ Both
☐ Abduction limited to 25 degrees from the side ☐ Right ☐ Left ☐ Both

10. Specific tests for rotator cuff conditions

a**.** Hawkins' Impingement Test (Forward flex the arm to 90 degrees with the elbow bent to 90 degrees. Internally rotate arm. Pain on internal rotation indicates a positive test; may signify rotator cuff tendinopathy or tear.)

☐ Positive ☐ Negative ☐ Unable to perform ☐ N/A
If positive, side affected: ☐ Right ☐ Left ☐ Both

b. Empty-can test (Abduct arm to 90 degrees and forward flex 30 degrees. Patient turns thumbs down and resists downward force applied by the examiner. Weakness indicates a positive test; may indicate rotator cuff pathology, including supraspinatus tendinopathy or tear.)

☐ Positive ☐ Negative ☐ Unable to perform ☐ N/A
If positive, side affected: ☐ Right ☐ Left ☐ Both

c. External rotation/Infraspinatus strength test (Patient holds arm at side with elbow flexed 90 degrees. Patient externally rotates against resistance. Weakness indicates a positive test; may be associated with infraspinatus tendinopathy or tear.)

☐ Positive ☐ Negative ☐ Unable to perform ☐ N/A
If positive, side affected: ☐ Right ☐ Left ☐ Both

d. Lift-off subscapularis test (Patient internally rotates arm behind lower back, pushes against examiner's hand. Weakness indicates a positive test; may indicate subscapularis tendinopathy or tear.)

☐ Positive ☐ Negative ☐ Unable to perform ☐ N/A

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

11. History and specific tests for instability/dislocation/labral pathology

a. Is there a history of mechanical symptoms (clicking, catching, etc.)?

☐ Yes ☐ No

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

b. Is there a history of recurrent dislocation (subluxation) of the glenohumeral (scapulohumeral) joint?

☐ Yes ☐ No

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

☐ Infrequent episodes	☐ Right	☐ Left	☐ Both
☐ Frequent episodes	☐ Right	☐ Left	☐ Both
☐ Guarding of movement only at shoulder level	☐ Right	☐ Left	☐ Both
☐ Guarding of all arm movements	☐ Right	☐ Left	☐ Both

c. Crank apprehension and relocation test (With patient supine, abduct patient's arm to 90 degrees and flex elbow 90 degrees. Pain and sense of instability with further external rotation may indicate shoulder instability.)

☐ Positive ☐ Negative ☐ Unable to perform ☐ N/A

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

12. History and specific tests for clavicle, scapula, acromioclavicular (AC) joint, and sternoclavicular joint conditions

a. Does the Veteran have an AC joint condition or any other impairment of the clavicle or scapula?

☐ Yes ☐ No

If yes, indicate severity and side affected:

☐ Malunion of clavicle or scapula	☐ Right	☐ Left	☐ Both
☐ Nonunion of clavicle or scapula without loose movement	☐ Right	☐ Left	☐ Both
☐ Nonunion of clavicle or scapula with loose movement	☐ Right	☐ Left	☐ Both
☐ Dislocation (acromioclavicular separation or sternoclavicular dislocation)	☐ Right	☐ Left	☐ Both
☐ Other, describe: _____	☐ Right	☐ Left	☐ Both

b. Is there tenderness on palpation of the AC joint?

☐ Yes ☐ No

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

c. Cross-body adduction test (Passively adduct arm across the patient's body toward the contralateral shoulder. Pain may indicate acromioclavicular joint pathology.)

☐ Positive ☐ Negative ☐ Unable to perform ☐ N/A

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

13. Joint replacement and/or other surgical procedures

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

☐ Yes ☐ No

If yes, indicate side and severity of residuals.

☐ Right shoulder

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 shoulder

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 shoulder 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 shoulder surgery?

☐ Yes ☐ No

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

If yes, describe residuals: _____

14. 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): _____

15. Remaining effective function of the extremities

Due to the Veteran shoulder and/or arm 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): _____

16. 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 shoulder been performed and are the results available?

☐ Yes ☐ No

If yes, is degenerative or traumatic arthritis documented?

☐ Yes ☐ No

If yes, indicate shoulder: ☐ 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): _____

17. Functional impact

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

☐ Yes ☐ No

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

_____

18. 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.

6.11. DBQ Skin Diseases

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 skin condition?

☐ Yes ☐ No

If yes, provide only diagnoses that pertain to skin conditions.

Indicate the category of skin condition, and then provide specific diagnosis in that category (check all that apply):

☐ Dermatitis or eczema
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Infectious skin conditions (including bacterial, fungal, viral, treponemal and parasitic skin conditions)
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Bullous disorders
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Psoriasis ICD code: _____ Date of diagnosis: _____

☐ Exfoliative dermatitis (erythroderma) ICD code: _____ Date of diagnosis: _____

☐ Cutaneous manifestations of collagen-vascular diseases
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Papulosquamous skin disorders
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Vitiligo
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Keratinization skin disorders
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Urticaria
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Primary cutaneous vasculitis

☐ Erythema multiforme ICD code: _____ Date of diagnosis: _____

☐ Acne ICD code: _____ Date of diagnosis: _____

☐ Chloracne ICD code: _____ Date of diagnosis: _____

☐ Alopecia ICD code: _____ Date of diagnosis: _____

☐ Hyperhidrosis ICD code: _____ Date of diagnosis: _____

☐ Tumors and neoplasms of the skin, including malignant melanoma
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Other skin condition
Other diagnosis #1: _____ ICD code: _____ Date of diagnosis: _____
Other diagnosis #2: _____ ICD code: _____ Date of diagnosis: _____
Other diagnosis #3: _____ ICD code: _____ Date of diagnosis: _____

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

2. Medical History

a. Describe the history (including onset and course) of the Veteran's skin conditions (brief summary):

_____

b. Do any of the Veteran's skin conditions cause scarring or disfigurement of the head, face or neck?

☐ Yes ☐ No

If yes, indicate skin condition and describe scarring and/or disfigurement: _____

Also complete the Scars Questionnaire if appropriate.

c. Does the Veteran have any benign or malignant skin neoplasms (including malignant melanoma)?

☐ Yes ☐ No

If yes, also complete the Tumors and Neoplasms Questionnaire.

d. Does the Veteran have any systemic manifestations due to any skin diseases (such as fever, weight loss or hypoproteinemia associated with skin conditions such as erythroderma)?

☐ Yes ☐ No

If yes, describe: _____

Also complete additional Questionnaires if appropriate.

3. Treatment

a. Has the Veteran been treated with oral or topical medications in the past 12 months for any skin condition)?

☐ Yes ☐ No

If yes, check all that apply:

☐ Systemic corticosteroids or other immunosuppressive medications
- If checked, list medication(s): _____
- Specify condition medication used for: _____
- Total duration of medication use in past 12 months:
  - ☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Antihistamines
- If checked, list medication(s): _____
- Specify condition medication used for: _____
- Total duration of medication use in past 12 months:
  - ☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Immunosuppressive retinoids
- If checked, list medication(s): _____
- Specify condition medication used for: _____
- Total duration of medication use in past 12 months:
  - ☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Sympathomimetics
- If checked, list medication(s): _____
- Specify condition medication used for: _____
- Total duration of medication use in past 12 months:
  - ☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Other oral medications
- If checked, list medication(s): _____
- Specify condition medication used for: _____
- Total duration of medication use in past 12 months:
  - ☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Topical corticosteroids
- If checked, list medication(s): _____
- Specify condition medication used for: _____
- Total duration of medication use in past 12 months:
  - ☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Other topical medications
If checked, list medication(s): _____
Specify condition medication used for: _____
Total duration of medication use in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

NOTE: If a medication is used for more than one condition, provide names of all conditions, name of medication used for each condition, and frequency of use for each condition: _____

b. Has the Veteran had any treatments or procedures other than systemic or topical medications in the past 12 months for exfoliative dermatitis or papulosquamous disorders?
☐ Yes ☐ No
If yes, check all that apply:

☐ PUVA (photo-chemotherapy with psoralen and ultraviolet A) treatment
If checked, specify condition treated: _____
Date of most recent treatment: _____
Total duration of treatment in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ UVB (ultraviolet B phototherapy) treatment
If checked, specify condition treated: _____
Date of most recent treatment: _____
Total duration of treatment in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Electron beam therapy
If checked, specify condition treated: _____
Date of most recent treatment: _____
Total duration of treatment in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Intensive light therapy
If checked, specify condition treated: _____
Date of most recent treatment: _____
Total duration of treatment in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Other treatment
Specify treatment: _____
Specify condition treated: _____
Date of most recent treatment: _____
Total duration of treatment in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

4. Debilitating and non-debilitating episodes

a. Has the Veteran had any debilitating episodes in the past 12 months due to urticaria, primary cutaneous vasculitis, erythema multiforme, or toxic epidermal necrolysis?
☐ Yes ☐ No
If yes, specify condition causing debilitating episodes:
☐ urticaria ☐ primary cutaneous vasculitis ☐ erythema multiforme ☐ toxic epidermal necrolysis
Describe debilitating episodes (brief summary): _____
Number of debilitating episodes in past 12 months:
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
Characteristics of debilitating episodes
☐ Occurred despite ongoing immunosuppressive therapy
☐ Required treatment with intermittent systemic immunosuppressive therapy
☐ Responded to treatment with antihistamines or sympathomimetics

b. Has the Veteran had any non-debilitating episodes of urticaria, primary cutaneous vasculitis, erythema multiforme, or toxic epidermal necrolysis in the past 12 months?
☐ Yes ☐ No
If yes, specify condition causing non-debilitating episodes:
☐ urticaria ☐ primary cutaneous vasculitis ☐ erythema multiforme ☐ toxic epidermal necrolysis
Describe episodes (brief summary): _____
Number of non-debilitating episodes in past 12 months:
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
Characteristics of non-debilitating episodes
☐ Occurred despite ongoing immunosuppressive therapy
☐ Required treatment with intermittent systemic immunosuppressive therapy
☐ Responded to treatment with antihistamines or sympathomimetics

NOTE: If the Veteran's debilitating and/or non-debilitating episodes are due to more than one condition, provide names of all conditions, indicating severity and frequency of episodes for each condition: _____

5. Physical exam
a. Indicate the Veteran's visible skin conditions; indicate the approximate total body area and approximate total EXPOSED body area (face, neck and hands) affected on current examination (check all that apply):

☐ Dermatitis	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
☐ Eczema	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
☐ Bullous disorder	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
☐ Psoriasis	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
☐ Infections of the skin						
	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
☐ Cutaneous manifestations of collagen-vascular disease						
	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
☐ Papulosquamous disorder						
	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%

☐ The Veteran does not have any of the above listed visible skin conditions

b. For each skin condition, give specific diagnosis and describe appearance and location: _____

6. Specific Skin Conditions
Indicate the Veteran's specific skin conditions and complete all applicable subsequent questions (check all that apply):
☐ Acne or Chloracne
If checked, indicate severity and location (check all that apply):
☐ Superficial acne (comedones, papules, pustules, superficial cysts) of any extent
☐ Deep acne (deep inflamed nodules and pus-filled cysts)
☐ Affects less than 40% of face and neck
☐ Affects 40% or more of face and neck
☐ Affects body areas other than face and neck

☐ Vitiligo
If checked, indicate areas affected by vitiligo:
☐ Exposed areas affected
☐ No exposed areas affected

☐ Scarring alopecia
If checked, indicate percent of scalp affected:
☐ < 20 % ☐ 20 to 40% ☐ > 40%

☐ Alopecia areata
If checked, indicate amount of hair loss:
☐ Hair loss limited to scalp and face ☐ Loss of all body hair
☐ Other, describe: _____

☐ Hyperhidrosis
If checked, indicate severity:
☐ Able to handle paper or tools after treatment
☐ Unresponsive to treatment; unable to handle paper or tools

☐ Veteran does not have any of the specific skin conditions listed above

7. Tumors and neoplasms

a. Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?
☐ Yes ☐ No
If yes, complete the following:

b. Is the neoplasm
☐ Benign ☐ Malignant

c. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?
☐ Yes ☐ No; watchful waiting
If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):
☐ Treatment completed; currently in watchful waiting status
☐ Surgery
If checked, describe: _____
Date(s) of surgery: _____
☐ Radiation therapy
Date of most recent treatment: _____
Date of completion of treatment or anticipated date of completion: _____
☐ Antineoplastic chemotherapy
Date of most recent treatment: _____
Date of completion of treatment or anticipated date of completion: _____ _____
☐ Other therapeutic procedure
If checked, describe procedure: _____
Date of most recent procedure: _____
☐ Other therapeutic treatment
If checked, describe treatment:
Date of completion of treatment or anticipated date of completion: _____

d. Does the Veteran currently have any residual conditions or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?
☐ Yes ☐ No
If yes, list residual conditions and complications (brief summary): _____

e. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the Diagnosis section, describe using the above format: _____

8. 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 related to any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, describe: _____

9. Functional impact
Do any of the Veteran's skin conditions impact his or her ability to work?
☐ Yes ☐ No
If yes, describe impact of each of the Veteran's skin 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.

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*172.

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:

download.vista.med.va.gov

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	ftp.fo-albany.med.va.gov	[anonymous.software]
Hines	ftp.fo-hines.med.va.gov	[anonymous.software]
Salt Lake City	ftp.fo-slc.med.va.gov	[anonymous.software]

File Name	Format	Description
DVBA_27_P172_RN.PDF	Binary	Release Notes

7.3 Related Documents

The VistA Documentation Library (VDL) web site will also contain the DVBA*2.7*172 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