



**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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Department of Veterans Affairs  
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 30°  Right  Left  Both
- In plantar flexion, between 30° and 40°  Right  Left  Both
- In plantar flexion, at more than 40°  Right  Left  Both
- In dorsiflexion, between 0° and 10°  Right  Left  Both
- In dorsiflexion, at more than 10°  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 calcaneus (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):

- |                                       |                   |                                     |                                  |                                   |
|---------------------------------------|-------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Wheelchair   | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Brace(s)     | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Crutch(es)   | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Cane(s)      | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Walker       | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Other: _____ | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> 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  $\geq 126$  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  $\geq 200$  mg/dl on glucose tolerance test

Date: \_\_\_\_\_

Random plasma glucose of  $\geq 200$  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:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Triceps:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Brachioradialis:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Knee:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Ankle:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+

c. Light touch/monofilament testing results:

All normal

Shoulder area:	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Inner/outer forearm:	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Hand/fingers:	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Knee/thigh:	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Ankle/lower leg:	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Foot/toes:	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> 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:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Left upper extremity:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Right lower extremity:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Left lower extremity:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> 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:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Left upper extremity:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Right lower extremity:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Left lower extremity:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent

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

Not tested

Right upper extremity:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Left upper extremity:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Right lower extremity:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Left lower extremity:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent

g. Does the Veteran have muscle atrophy?

Yes  No

If muscle atrophy is present, indicate location: \_\_\_\_\_

For each instance of muscle atrophy, provide measurements in 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:

<input type="checkbox"/> Right upper extremity	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Date: _____
<input type="checkbox"/> Left upper extremity	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Date: _____
<input type="checkbox"/> Right lower extremity	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Date: _____
<input type="checkbox"/> Left lower extremity	Results: <input type="checkbox"/> Normal <input type="checkbox"/> 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:

- |  |                                |                               |                               |
|--|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Homonymous hemianopsia                | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Loss of temporal half of visual field | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Loss of nasal half of visual field    | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Loss of inferior half of visual field | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Loss of superior half of visual field | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, specify: _____                 | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

d. Does the Veteran have a scotoma?

- Yes  No

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

- |   |                                |                               |                               |
|---|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Scotoma affecting at least 1/4 of the visual field | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Centrally located scotoma                          | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> 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)

- |   |                                |                               |                               |
|---|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Drusen of optic disc         | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Ischemic optic neuropathy    | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Nutritional optic neuropathy | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Optic atrophy                | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, describe _____        | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> 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)

- |   |                                |                               |                               |
|---|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Retinopathy  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Maculopathy  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Detached retina  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Retinal hemorrhage   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Centrally located retinal scars, atrophy or irregularities in either eye that result in an irregular, duplicated, enlarged or diminished image in either eye | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> 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 3<sup>rd</sup> cranial nerve (oculomotor)  
Eye affected:  Right  Left  Both
- Paresis/paralysis of 4<sup>th</sup> cranial nerve (trochlear)  
Eye affected:  Right  Left  Both
- Paresis/paralysis of 6<sup>th</sup> cranial nerve (abducens)  
Eye affected:  Right  Left  Both
- Paresis/paralysis of 7<sup>th</sup> 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: \_\_\_\_\_  
 Normal  Abnormal, specify: \_\_\_\_\_

d. Heart sounds:

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:

- |   |                                |                               |                               |
|---|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> No symptoms                          | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Meniscal dislocation                 | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Meniscal tear                        | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Frequent episodes of joint "locking" | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Frequent episodes of joint pain      | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Frequent episodes of joint effusion  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> 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:

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**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:

---

---

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**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:

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**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: \_\_\_\_\_ cm<sup>2</sup>

Left upper extremity: Approximate total area: \_\_\_\_\_ cm<sup>2</sup>

Right lower extremity: Approximate total area: \_\_\_\_\_ cm<sup>2</sup>

Left lower extremity: Approximate total area: \_\_\_\_\_ cm<sup>2</sup>

Anterior trunk: Approximate total area: \_\_\_\_\_ cm<sup>2</sup>

Posterior trunk: Approximate total area: \_\_\_\_\_ cm<sup>2</sup>

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: \_\_\_\_\_ cm<sup>2</sup>

Left upper extremity: Approximate total area: \_\_\_\_\_ cm<sup>2</sup>

Right lower extremity: Approximate total area: \_\_\_\_\_ cm<sup>2</sup>

Left lower extremity: Approximate total area: \_\_\_\_\_ cm<sup>2</sup>

Anterior trunk: Approximate total area: \_\_\_\_\_ cm<sup>2</sup>

Posterior trunk: Approximate total area: \_\_\_\_\_ cm<sup>2</sup>

**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: \_\_\_\_\_ cm<sup>2</sup>  
b. Approximate total area of head, face and neck with abnormal texture: \_\_\_\_\_ cm<sup>2</sup>  
c. Approximate total area of head, face and neck with missing underlying soft tissue: \_\_\_\_\_ cm<sup>2</sup>  
d. Approximate total area of head, face and neck that is indurated and inflexible: \_\_\_\_\_ cm<sup>2</sup>

## **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:

**REDACTED**

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

<b>OI&amp;T Field Office</b>	<b>FTP Address</b>	<b>Directory</b>
<b>Albany</b>	REDACTED	[anonymous.software]
<b>Hines</b>	REDACTED	[anonymous.software]
<b>Salt Lake City</b>	REDACTED	[anonymous.software]

<b>File Name</b>	<b>Format</b>	<b>Description</b>
<b>DVBA_27_P172_RN.PDF</b>	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>