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

July 2011

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Office of Enterprise Development
Management & Financial Systems
Preface

Purpose of the Release Notes
The Release Notes document describes the new features and functionality of patch DVBA*2.7*172.
(CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs).

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

The purpose of this document is to provide an overview of the enhancements specifically designed for Patch DVBA*2.7*172.

Patch DVBA *2.7*172 (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs) introduces enhancements and updates made to the AUTOMATED MED INFO EXCHANGE (AMIE) V 2.7 package and the Compensation & Pension Record Interchange (CAPRI) application in support of the new Compensation and Pension (C&P) Disability Benefits Questionnaires (DBQs).

2. Overview

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

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

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

3. Associated Remedy Tickets & New Service Requests

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

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

5. Enhancements

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

5.1 CAPRI – DBQ Template Additions

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

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

5.2 CAPRI – DBQ Template Deactivation

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

- DBQ MEDICAL OPINION

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

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

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

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

5.4 AMIE–DBQ Worksheet Deactivation

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

- DBQ MEDICAL OPINION

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

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

6.1. DBQ Ankle Conditions

Name of patient/Veteran: ____________________________ SSN: __________________________

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

1. Diagnosis

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

If yes, provide only diagnoses that pertain to ankle condition(s):

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

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

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

If there are additional diagnoses pertaining to ankle conditions, list using above format: ____________________________

2. Medical History

Describe the history (including onset and course) of the Veteran’s ankle condition (brief summary): __________

3. Flare-ups

Does the Veteran report that flare-ups impact the function of the ankle?
☐ Yes  ☐ No

If yes, document the Veteran’s description of the impact of flare-ups in his or her own words: __________

4. Initial range of motion (ROM) measurements:

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

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use testing must be included in all joint exams. The VA has determined that 3 repetitions of ROM (at a minimum) can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM after 3 repetitions. Report post-test measurements in section 5.
a. Right ankle plantar flexion  
Select where plantar flexion ends (normal endpoint is 45 degrees):

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

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion

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

b. Right ankle dorsiflexion (extension)
Select where dorsiflexion (extension) ends (normal endpoint is 20 degrees):

☐ 0  ☐ 5  ☐ 10  ☐ 15  ☐ 20 or greater

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion

☐ 0  ☐ 5  ☐ 10  ☐ 15  ☐ 20 or greater

c. Left ankle plantar flexion
Select where plantar flexion ends (normal endpoint is 45 degrees):

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

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion

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

d. Left ankle plantar dorsiflexion (extension)
Select where dorsiflexion (extension) ends (normal endpoint is 20 degrees):

☐ 0  ☐ 5  ☐ 10  ☐ 15  ☐ 20 or greater

Select where objective evidence of painful motion begins:
☐ No objective evidence of painful motion

☐ 0  ☐ 5  ☐ 10  ☐ 15  ☐ 20 or greater

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

5. ROM measurements after repetitive use testing
Is the Veteran able to perform repetitive-use testing with 3 repetitions?
☐ Yes    ☐ No   If unable, provide reason: __________________

If Veteran is unable to perform repetitive-use testing, skip to section 6.
If Veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions.

a. Right ankle post-test ROM  
Select where post-test plantar flexion ends:

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

Select where post-test dorsiflexion (extension) ends:

☐ 0  ☐ 5  ☐ 10  ☐ 15  ☐ 20 or greater

b. Left ankle post-test ROM
Select where post-test plantar flexion ends:

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

Select where post-test dorsiflexion (extension) ends:

☐ 0  ☐ 5  ☐ 10  ☐ 15  ☐ 20 or greater
6. Functional loss and additional limitation in ROM

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

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

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

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

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

7. Pain (pain on palpation)

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

8. Muscle strength testing

Rate strength according to the following scale:

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

Ankle plantar flexion:  
   □ Right:  □ 5/5  □ 4/5  □ 3/5  □ 2/5  □ 1/5  □ 0/5  
   □ Left:  □ 5/5  □ 4/5  □ 3/5  □ 2/5  □ 1/5  □ 0/5

Ankle dorsiflexion:  
   □ Right:  □ 5/5  □ 4/5  □ 3/5  □ 2/5  □ 1/5  □ 0/5  
   □ Left:  □ 5/5  □ 4/5  □ 3/5  □ 2/5  □ 1/5  □ 0/5

9. Joint stability

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

10. Ankylosis
Does the Veteran have ankylosis of the ankle, subtalar and/or tarsal joint?
☐ Yes ☐ No
If yes, indicate severity of ankylosis and side affected (check all that apply):
   ☐ In plantar flexion, less than 30º ☐ Right ☐ Left ☐ Both
   ☐ In plantar flexion, between 30º and 40º ☐ Right ☐ Left ☐ Both
   ☐ In plantar flexion, at more than 40º ☐ Right ☐ Left ☐ Both
   ☐ In dorsiflexion, between 0º and 10º ☐ Right ☐ Left ☐ Both
   ☐ In dorsiflexion, at more than 10º ☐ Right ☐ Left ☐ Both
   ☐ With abduction, adduction, inversion or eversion deformity
      ☐ Right ☐ Left ☐ Both
   ☐ In good weight-bearing position ☐ Right ☐ Left ☐ Both
   ☐ In poor weight-bearing position ☐ Right ☐ Left ☐ Both

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

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

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

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

d. ☐ Malunion of 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):
□ Wheelchair Frequency of use: □ Occasional □ Regular □ Constant
□ Brace(s) Frequency of use: □ Occasional □ Regular □ Constant
□ Crutch(es) Frequency of use: □ Occasional □ Regular □ Constant
□ Cane(s) Frequency of use: □ Occasional □ Regular □ Constant
□ Walker Frequency of use: □ Occasional □ Regular □ Constant
□ Other: __________ Frequency of use: □ Occasional □ Regular □ Constant

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

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

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

a. Have imaging studies of the ankle been performed and are the results available?
☐ Yes  ☐ No
If yes, are there abnormal findings?
☐ Yes  ☐ No
  If yes, indicate findings:
    ☐ Degenerative or traumatic arthritis
      ankle: ☐ Right  ☐ Left  ☐ Both
    ☐ Ankylosis
      ankle: ☐ Right  ☐ Left  ☐ Both
    ☐ Other. Describe: _______________________

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 any worsening of the condition is not due to natural progress) any of the following conditions?
   Check all that apply:
   ☐ Cardiac condition(s)  If checked, also complete appropriate cardiac Questionnaire (IHD or other cardiac Questionnaire).
   ☐ Hypertension  If checked, also complete Hypertension Questionnaire
   ☐ Renal disease  If checked, also complete Kidney Questionnaire
   ☐ Peripheral vascular disease  If checked, also complete Arteries and Veins Questionnaire.
   ☐ Eye condition(s) other than diabetic retinopathy  If checked, also complete Eye Questionnaire. (Eye Questionnaire must be completed by ophthalmologist or optometrist)
   ☐ Other permanently aggravated condition(s) (describe): _______________________
   ☐ None
4. Other pertinent physical findings, complications, conditions, signs and/or symptoms
a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
   - Yes
   - No
   - If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
     - Yes
     - No
     - If yes, also complete a Scars Questionnaire.

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

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

Test results used to make the diagnosis of DM (if known): (check all that apply)
- Fasting plasma glucose test (FPG) of ≥126 mg/dl on 2 or more occasions Dates:
- A1C of 6.5% or greater on 2 or more occasions Dates: ______
- 2-hr plasma glucose of ≥200 mg/dl on glucose tolerance test Date: ______
- Random plasma glucose of ≥200 mg/dl with classic symptoms of hyperglycemia Date: ______
- Other, describe: ______________________________________

Current test results:
- Most recent A1C, if available: ______ Date: ______
- Most recent fasting plasma glucose, if available: ______ Date: ______

6. Functional impact
Does the Veteran’s DM (and complications of DM if present) impact his or her ability to work? (Impact on ability to work may also be addressed on the individual Questionnaire(s) for other diabetes-associated conditions and/or complications, if completed.)
   - Yes
   - No
   - If yes, separately describe impact of the Veteran’s DM, diabetes-associated conditions, and complications, if present, providing one or more examples: ______________________________________

7. Remarks, if any:

   ________________________________________________________________

   Physician signature: __________________________________________ Date: ___
   Physician printed name: ________________________________________
   Medical license #: _____________ Physician address: ________________
   Phone: ____________________ Fax: _____________________________

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
6.3. DBQ Diabetic Sensory- Motor Peripheral Neuropathy

Name of patient/Veteran: _____________________________________  SSN: ___________

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

1. Diagnosis
Does the Veteran now have or has he/she ever been diagnosed with diabetic peripheral neuropathy?
☐ Yes  ☐ No

If yes, provide only diagnoses that pertain to diabetic peripheral neuropathy:
Diagnosis #1: ____________________
ICD code: ____________________
Date of diagnosis: _____________

Diagnosis #2: ____________________
ICD code: ____________________
Date of diagnosis: _____________

Diagnosis #3: ____________________
ICD code: ____________________
Date of diagnosis: _____________

If there are additional diagnoses that pertain to diabetic peripheral neuropathy, list using above format: ___________

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

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

c. Dominant hand
☐ Right  ☐ Left  ☐ Ambidextrous

3. Symptoms
a. Does the Veteran have any symptoms attributable to diabetic peripheral neuropathy?
☐ Yes  ☐ No

If yes, indicate symptoms’ location and severity (check all that apply):

Constant pain (may be excruciating at times)

- Right upper extremity:  ☐ None  ☐ Mild  ☐ Moderate  ☐ Severe
- Left upper extremity:  ☐ None  ☐ Mild  ☐ Moderate  ☐ Severe
- Right lower extremity:  ☐ None  ☐ Mild  ☐ Moderate  ☐ Severe
- Left lower extremity:  ☐ None  ☐ Mild  ☐ Moderate  ☐ Severe
Intermittent pain (usually dull)
- Right upper extremity: None, Mild, Moderate, Severe
- Left upper extremity: None, Mild, Moderate, Severe
- Right lower extremity: None, Mild, Moderate, Severe
- Left lower extremity: None, Mild, Moderate, Severe

Paresthesias and/or dysesthesias
- Right upper extremity: None, Mild, Moderate, Severe
- Left upper extremity: None, Mild, Moderate, Severe
- Right lower extremity: None, Mild, Moderate, Severe
- Left lower extremity: None, Mild, Moderate, Severe

Numbness
- Right upper extremity: None, Mild, Moderate, Severe
- Left upper extremity: None, Mild, Moderate, Severe
- Right lower extremity: None, Mild, Moderate, Severe
- Left lower extremity: None, Mild, Moderate, Severe

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

4. Neurologic exam
a. Strength
   Rate strength according to the following scale:
   - 0/5 No muscle movement
   - 1/5 Visible muscle movement, but no joint movement
   - 2/5 No movement against gravity
   - 3/5 No movement against resistance
   - 4/5 Less than normal strength
   - 5/5 Normal strength
   - All normal

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

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

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

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

   Grip: Right: 5/5, 4/5, 3/5, 2/5, 1/5, 0/5
   Left: 5/5, 4/5, 3/5, 2/5, 1/5, 0/5

   Pinch (thumb to index finger):
   Right: 5/5, 4/5, 3/5, 2/5, 1/5, 0/5
   Left: 5/5, 4/5, 3/5, 2/5, 1/5, 0/5

   Knee extension: Right: 5/5, 4/5, 3/5, 2/5, 1/5, 0/5
   Left: 5/5, 4/5, 3/5, 2/5, 1/5, 0/5

   Knee flexion: Right: 5/5, 4/5, 3/5, 2/5, 1/5, 0/5
   Left: 5/5, 4/5, 3/5, 2/5, 1/5, 0/5

   Ankle plantar flexion: Right: 5/5, 4/5, 3/5, 2/5, 1/5, 0/5
   Left: 5/5, 4/5, 3/5, 2/5, 1/5, 0/5

   Ankle dorsiflexion: Right: 5/5, 4/5, 3/5, 2/5, 1/5, 0/5
   Left: 5/5, 4/5, 3/5, 2/5, 1/5, 0/5

b. Deep tendon reflexes (DTRs)
   Rate reflexes according to the following scale:
   - 0 Absent
   - 1+ Decreased


<table>
<thead>
<tr>
<th>Muscles</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biceps</td>
<td>1+</td>
<td>2+</td>
</tr>
<tr>
<td>Triceps</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Brachioradialis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Knee</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ankle</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**c. Light touch/monofilament testing results:**

<table>
<thead>
<tr>
<th>Area</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder area</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Inner/outer forearm</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Hand/fingers</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Knee/thigh</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Ankle/lower leg</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Foot/toes</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Extremity</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right upper extremity</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Left upper extremity</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Right lower extremity</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Left lower extremity</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Extremity</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right upper extremity</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Left upper extremity</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Right lower extremity</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Left lower extremity</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Extremity</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right upper extremity</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Left upper extremity</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Right lower extremity</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Left lower extremity</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
</tbody>
</table>

**g. Does the Veteran have muscle atrophy?**

- Yes □
- No □

If muscle atrophy is present, indicate location: __________

---

July 2011

DVBA*2.7*172 Release Notes
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
<table>
<thead>
<tr>
<th>Left:</th>
<th>Normal</th>
<th>Incomplete paralysis</th>
<th>Complete paralysis</th>
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</thead>
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<tr>
<td></td>
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<td>If Incomplete paralysis is checked, indicate severity:</td>
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<td>Mild</td>
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</table>

**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).

<table>
<thead>
<tr>
<th>Right:</th>
<th>Normal</th>
<th>Incomplete paralysis</th>
<th>Complete paralysis</th>
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<td>If Incomplete paralysis is checked, indicate severity:</td>
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<td>Mild</td>
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</table>

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</table>

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).

<table>
<thead>
<tr>
<th>Right:</th>
<th>Normal</th>
<th>Incomplete paralysis</th>
<th>Complete paralysis</th>
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<td>If Incomplete paralysis is checked, indicate severity:</td>
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<td>Mild</td>
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<table>
<thead>
<tr>
<th>Left:</th>
<th>Normal</th>
<th>Incomplete paralysis</th>
<th>Complete paralysis</th>
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<td>If Incomplete paralysis is checked, indicate severity:</td>
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<td>Mild</td>
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**Femoral nerve (anterior crural)**

Note: Complete paralysis (paralysis of quadriceps extensor muscles).

<table>
<thead>
<tr>
<th>Right:</th>
<th>Normal</th>
<th>Incomplete paralysis</th>
<th>Complete paralysis</th>
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<td>If Incomplete paralysis is checked, indicate severity:</td>
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<tr>
<th>Left:</th>
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<th>Complete paralysis</th>
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<td>If Incomplete paralysis is checked, indicate severity:</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Mild</td>
</tr>
</tbody>
</table>
6. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
   - Yes □ No □

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
   - Yes □ No □

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?
   - Yes □ No □

If yes, describe (brief summary): ____________________________

7. Diagnostic testing

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

a. Have EMG studies been performed?
   - Yes □ No □

Extremities tested:
   - Right upper extremity Results: □ Normal □ Abnormal Date: __________
   - Left upper extremity Results: □ Normal □ Abnormal Date: __________
   - Right lower extremity Results: □ Normal □ Abnormal Date: __________
   - Left lower extremity Results: □ Normal □ Abnormal Date: __________

If abnormal, describe: ____________________________

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

8. Functional impact

Does the Veteran’s diabetic peripheral neuropathy impact his or her ability to work?
   - Yes □ No □

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

9. Remarks, if any:

____________________________________________________________________________________

____________________________________________________________________________________

Physician signature: __________________________________________ Date: __________
Physician printed name: __________________________________________
Medical license #: ____________________ Physician address: _____________________________
Phone: ____________________ Fax: _____________________________

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
6.4. DBQ Eye Conditions

Name of patient/Veteran: ________________________________ SSN: ____________________

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

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

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

If yes, provide only diagnoses that pertain to eye conditions:

Diagnosis #1: __________________
ICD code(s): __________________
Date of diagnosis: ______________

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

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

If there are additional diagnoses that pertain to eye conditions, list using above format: ______________

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

SECTION III: PHYSICAL EXAMINATION

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

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

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

b. Uncorrected near:
Right: □ 5/200 □ 10/200 □ 15/200 □ 20/200 □ 20/100 □ 20/70 □ 20/50 □ 20/40 or better
Left: □ 5/200 □ 10/200 □ 15/200 □ 20/200 □ 20/100 □ 20/70 □ 20/50 □ 20/40 or better
c. Corrected distance:
   Right: 5/200 10/200 15/200 20/200 20/100 20/70 20/50 20/40 or better
   Left: 5/200 10/200 15/200 20/200 20/100 20/70 20/50 20/40 or better

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

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

   a. Provide a second recording of corrected distance and near vision:
      Second recording of corrected distance vision:
         Right: 5/200 10/200 15/200 20/200 20/100 20/70 20/50 20/40 or better
         Left: 5/200 10/200 15/200 20/200 20/100 20/70 20/50 20/40 or better
      Second recording of corrected near vision:
         Right: 5/200 10/200 15/200 20/200 20/100 20/70 20/50 20/40 or better
         Left: 5/200 10/200 15/200 20/200 20/100 20/70 20/50 20/40 or better
      b. Explain reason for the difference between distance and near corrected vision: ____________
      c. Does the lens required to correct distance vision in the poorer eye differ by more than 3 diopters from the lens required to correct distance vision in the better eye?
         □ Yes  □ No
         If yes, explain reason for the difference: ____________

3. Pupils
   a. Pupil diameter: Right: _____mm    Left: _____mm
   b. □ Pupils are round and reactive to light
   c. Is an afferent pupillary defect present?
      □ Yes  □ No
      If yes, indicate eye: □ Right  □ Left
   d. □ Other, describe: ________________
      Eye affected: □ Right  □ Left  □ Both

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

   a. Does the Veteran have anatomical loss of either eye?
      □ Yes  □ No
      If yes, indicate eye:
         □ Right  □ Left  □ Both
      If yes, is Veteran able to wear an ocular prosthesis?
         □ Yes  □ No
      If no, provide reason: ________________________________________________________
b. Is the Veteran’s vision limited to no more than light perception only in either eye?
   □ Yes  □ No
   If yes, indicate for which eye(s) the Veteran’s vision limited to no more than light perception:
   □ Right  □ Left  □ Both

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

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

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

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

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

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

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

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

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

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

☐ Yes  ☐ No

If yes, complete the following section:

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

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

a. Was visual field testing performed?

☐ Yes  ☐ No

Results:

☐ Using Goldmann’s equivalent III/4e target
☐ Using Goldmann’s equivalent IV/4e target (used for aphakic individuals not well adapted to contact lens correction or pseudophakic individuals not well adapted to intraocular lens implant)
☐ Other, describe: ______________________

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

☐ Yes  ☐ No

If yes, include Goldmann chart with this Questionnaire.

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

☐ Yes  ☐ No

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

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

D. Does the Veteran have a scotoma?

☐ Yes  ☐ No

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

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

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

☐ Yes  ☐ No

**SECTION IV: Eye conditions**

1. **Conditions**

Does the Veteran have any of the following eye conditions?

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

- Anatomical loss of eyelids, brows, lashes
- Lacrimal gland and lid disorders (other than ptosis or anatomic loss)
- Ptosis, for either or both eyelids
- Conjunctivitis and other conjunctival conditions
- Corneal conditions
- Cataract and other lens conditions
- Inflammatory eye conditions and/or injuries
- Glaucoma
- Optic neuropathy and other disc conditions
- Retinal conditions
- Neurogenic eye conditions
- Tumors and neoplasms
- Other eye conditions

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
      - Complete loss of eyebrows
      - Complete loss of eyelashes

   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

   c. If present, does eyelid loss cause scarring or disfigurement?
      - Yes
      - No

3. Lacrimal gland and lid conditions

   a. Indicate the Veteran’s condition(s) and side affected (check all that apply):
      - Ectropion
      - Entropion
      - Lagophthalmos
      - Disorder of the lacrimal apparatus (epiphora, dacryocystitis, etc.)

   b. If present, does lacrimal or lid condition cause scarring or disfigurement?
      - Yes
      - No

4. Ptosis

   a. If ptosis is present, indicate side affected:

   b. Is the Veteran’s decrease in visual acuity or other visual impairment, if present, attributable to ptosis?
      - Yes
      - No
      - There is no decrease in visual acuity or other visual impairment

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

5. Conjunctivitis and other conjunctival conditions
a. Indicate type of conjunctivitis, activity, and side affected (check all that apply):
   ☐ Trachomatous:
      ☐ Active  Eye affected: ☐ Right  ☐ Left  ☐ Both
      ☐ Inactive Eye affected: ☐ Right  ☐ Left  ☐ Both
   ☐ Nontrachomatous:
      ☐ Active  Eye affected: ☐ Right  ☐ Left  ☐ Both
      ☐ Inactive Eye affected: ☐ Right  ☐ Left  ☐ Both
b. Indicate the Veteran's other conjunctival conditions, if any (check all that apply):
   ☐ Pinguecula Eye affected: ☐ Right  ☐ Left  ☐ Both
   ☐ Symblepharon Eye affected: ☐ Right  ☐ Left  ☐ Both
   ☐ Other, describe: _____________________________
                    Eye affected: ☐ Right  ☐ Left  ☐ Both
c. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the eye conditions checked above in this section?
☐ Yes  ☐ No  ☐ There is no decrease in visual acuity or other visual impairment
If no, explain: ________________________________
d. Does any eye condition identified in this section cause scarring or disfigurement?
☐ Yes  ☐ No
If yes, complete Section IV, Scarring and disfigurement.

6. Corneal conditions
a. Has the Veteran had a corneal transplant?
☐ Yes  ☐ No
If yes, indicate side of transplant: ☐ Right  ☐ Left  ☐ Both
Indicate residuals (check all that apply):
   ☐ Pain  Eye affected: ☐ Right  ☐ Left  ☐ Both
   ☐ Photophobia Eye affected: ☐ Right  ☐ Left  ☐ Both
   ☐ Glare sensitivity Eye affected: ☐ Right  ☐ Left  ☐ Both
   ☐ Other, describe: _____________________________
                    Eye affected: ☐ Right  ☐ Left  ☐ Both
b. Does the Veteran have keratoconus?
☐ Yes  ☐ No
If yes, indicate eye affected: ☐ Right  ☐ Left  ☐ Both
c. Does the Veteran have a pterygium?
☐ Yes  ☐ No
If yes, indicate eye affected: ☐ Right  ☐ Left  ☐ Both
d. Does the Veteran have another corneal condition that may result in an irregular cornea?
(For example, pellucid marginal degeneration, irregular astigmatism from corneal scar, post-laser refractive surgery, acne rosacea keratopathy, etc.)
☐ Yes  ☐ No
If yes, specify corneal condition: ________________________________
                    Eye affected: ☐ Right  ☐ Left  ☐ Both
e. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to keratoconus or
another corneal condition, if present?
☐ Yes  ☐ No  ☐ There is no decrease in visual acuity or other visual impairment
If yes, specify corneal condition responsible for visual impairment ____________.
If no, explain: __________________________________________

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

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

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

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

8. Inflammatory eye conditions and/or injuries
a. Indicate the Veteran’s condition and eye affected:
   ☐ Choroidopathy (including uveitis, iritis, cyclitis, and choroiditis)  ☐ Right  ☐ Left  ☐ Both
   ☐ Keratopathy  ☐ Right  ☐ Left  ☐ Both
   ☐ Scleritis  ☐ Right  ☐ Left  ☐ Both
   ☐ Intraocular hemorrhage  ☐ Right  ☐ Left  ☐ Both
   ☐ Unhealed eye injury  ☐ Right  ☐ Left  ☐ Both
   ☐ Other, describe: ______________________________  ☐ Right  ☐ Left  ☐ Both

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

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

9. Glaucoma
a. Specify the type of glaucoma:
   ☐ Angle-closure  Eye affected: ☐ Right  ☐ Left  ☐ Both
   ☐ Open-angle  Eye affected: ☐ Right  ☐ Left  ☐ Both
   ☐ Other, specify type (For example, neovascular, phakolytic, etc.)  ______________________________
      Eye affected: ☐ Right  ☐ Left  ☐ Both
b. Does the glaucoma require continuous medication for treatment?  
☐ Yes  ☐ No  
If yes, indicate eye affected: ☐ Right  ☐ Left  ☐ Both  
List medication(s) used for treatment of glaucoma: ____________________________

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

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

10. Optic neuropathy and other disc conditions  
a. Indicate optic neuropathy and other disc conditions, and eye affected: (check all that apply)  
☐ Drusen of optic disc  ☐ Right  ☐ Left  ☐ Both  
☐ Ischemic optic neuropathy  ☐ Right  ☐ Left  ☐ Both  
☐ Nutritional optic neuropathy  ☐ Right  ☐ Left  ☐ Both  
☐ Optic atrophy  ☐ Right  ☐ Left  ☐ Both  
☐ Other, describe ____________________________  ☐ Right  ☐ Left  ☐ Both

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

11. Retinal conditions  
a. Indicate retinal condition, and eye affected: (check all that apply)  
☐ Retinopathy  ☐ Right  ☐ Left  ☐ Both  
☐ Maculopathy  ☐ Right  ☐ Left  ☐ Both  
☐ Detached retina  ☐ Right  ☐ Left  ☐ Both  
☐ Retinal hemorrhage  ☐ Right  ☐ Left  ☐ Both  
☐ Centrally located retinal scars, atrophy or irregularities in either eye that result in an irregular, duplicated,  
enlarged or diminished image in either eye  ☐ Right  ☐ Left  ☐ Both

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

12. Neurologic eye conditions  
a. Indicate the Veteran’s neurologic eye condition/disorder:  
☐ Nystagmus  
If checked, is nystagmus etiology central? ☐ Yes  ☐ No  
☐ Paresis/paralysis of 3rd cranial nerve (oculomotor)  
Eye affected: ☐ Right  ☐ Left  ☐ Both  
☐ Paresis/paralysis of 4th cranial nerve (trochlear)  
Eye affected: ☐ Right  ☐ Left  ☐ Both  
☐ Paresis/paralysis of 6th cranial nerve (abducens)  
Eye affected: ☐ Right  ☐ Left  ☐ Both  
☐ Paresis/paralysis of 7th cranial nerve (facial, Bell’s palsy)  
Eye affected: ☐ Right  ☐ Left  ☐ Both
Eye condition due to cerebrovascular accident (CVA)
If checked, specify eye condition attributable to CVA: ____________
Eye affected: [ ] Right [ ] Left [ ] Both

Eye condition due to demyelinating disease
If checked, specify eye condition attributable to demyelinating disease: ____________
Eye affected: [ ] Right [ ] Left [ ] Both

Optic neuritis
Eye affected: [ ] Right [ ] Left [ ] Both

Eye condition due to intracranial mass/tumor
If checked, specify eye condition attributable to intracranial mass/tumor: ____________
Eye affected: [ ] Right [ ] Left [ ] Both

Eye disorder due to traumatic brain injury (TBI)
If checked, specify eye condition attributable to TBI: ____________
Eye affected: [ ] Right [ ] Left [ ] Both

Other
If checked, specify neurologic eye condition/disorder and name the underlying neurologic condition (for example, Alzheimer's disease, Jakob-Creutzfeldt disease, etc.): _______________________________
Eye affected: [ ] Right [ ] Left [ ] Both

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

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

a. Is the neoplasm:
[ ] Benign [ ] Malignant

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

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

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

e. Does any benign or malignant neoplasms or metastases identified in this section cause scarring or disfigurement?
☐ Yes ☐ No
If yes, complete Section IV, Scarring and disfigurement.

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

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

For all checked conditions, describe scarring and/or disfigurement: ______________________
NOTE: If possible, include color photographs with any report of scarring or disfigurement.

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

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

SECTION VII
1. Functional impact
Does the Veteran’s eye condition(s) impact his or her ability to work?
☐ Yes ☐ No
If yes, describe the impact of each of the Veteran’s eye condition(s), providing one or more examples: _______
2. Remarks, if any: __________________________________________________________________________

Optometrist/Physician signature: ________________________________ Date: ____________________
Optometrist/Physician printed name: ______________________________
Optometric/Medical license #: ________________________________ State of licensure: __________________
Optometrist/Physician address: ________________________________ Phone: ____________________
Fax: ____________________

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
6.5. DBQ Heart Conditions: (including Ischemic & Heart Disease, Arrhythmias, Valvular Disease and Cardiac Surgery)

Name of patient/Veteran: _____________________________________ SSN: ________________________

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

1. Diagnosis

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

If yes, select the Veteran’s heart condition(s) (check all that apply):
☐ Acute, subacute, or old myocardial infarction
   ICD code: __________ Date of diagnosis: ____________

☐ Atherosclerotic cardiovascular disease
   ICD code: __________ Date of diagnosis: ____________

☐ Coronary artery disease
   ICD code: __________ Date of diagnosis: ____________

☐ Stable angina
   ICD code: __________ Date of diagnosis: ____________

☐ Unstable angina
   ICD code: __________ Date of diagnosis: ____________

☐ Coronary spasm, including Prinzmetal’s angina
   ICD code: __________ Date of diagnosis: ____________

☐ Congestive heart failure
   ICD code: __________ Date of diagnosis: ____________

☐ Supraventricular arrhythmia
   ICD code: __________ Date of diagnosis: ____________

☐ Ventricular arrhythmia
   ICD code: __________ Date of diagnosis: ____________

☐ Heart block
   ICD code: __________ Date of diagnosis: ____________

☐ Valvular heart disease
   ICD code: __________ Date of diagnosis: ____________

☐ Heart valve replacement
   ICD code: __________ Date of diagnosis: ____________

☐ Cardiomyopathy
   ICD code: __________ Date of diagnosis: ____________

☐ Hypertensive heart disease
   ICD code: __________ Date of diagnosis: ____________

☐ Heart transplant
   ICD code: __________ Date of diagnosis: ____________

☐ Implanted cardiac pacemaker
   ICD code: __________ Date of diagnosis: ____________

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

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

☐ Pericardial adhesions
   ICD code: __________ Date of diagnosis: ____________

☐ Other heart condition, specify below
   Other diagnosis #1: ______________
   ICD code: __________ Date of diagnosis: ____________

☐ Other heart condition, specify below
   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 □ 1-4 □ 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: ______

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

☐ Yes ☐ No

If yes, complete the following:

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

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

11. Physical exam

a. Heart rate: _______

b. Rhythm: ☐ Regular ☐ Irregular

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

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

e. Jugular-venous distension: ☐ Yes ☐ No

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

g. Peripheral pulses:
   Dorsalis pedis: ☐ Normal ☐ Diminished ☐ Absent
   Posterior tibial: ☐ Normal ☐ Diminished ☐ Absent

h. Peripheral edema:
   Right lower extremity: ☐ None ☐ Trace ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+
   Left lower extremity: ☐ None ☐ Trace ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+

i. Blood pressure: ________________

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

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

☐ Yes ☐ No

If yes, describe (brief summary): _________________________

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

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

a. Is there evidence of cardiac hypertrophy?

☐ Yes ☐ No

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

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

c. Diagnostic tests
   Indicate all testing completed; provide only most recent results which reflect the Veterans current functional status (check all that apply):
   ☐ EKG
      Date of EKG: ______________
      Result: ☐ Normal  ☐ Arrhythmia, describe: ________________________
      ☐ Hypertrophy, describe: ________________________
      ☐ Ischemia, describe: ________________________
      ☐ Other, describe: ________________________
   ☐ Chest x-ray
      Date of CXR: ______________
      Result: ☐ Normal  ☐ Abnormal, describe: ________________________
   ☐ Echocardiogram
      Date of echocardiogram: ______
      Left ventricular ejection fraction (LVEF): _____%
      Wall motion: ☐ Normal  ☐ Abnormal, describe: ________________________
      Wall thickness: ☐ Normal  ☐ Abnormal, describe: ________________________
   ☐ Holter monitor
      Date of Holter monitor: ______
      Result: ☐ Normal  ☐ Abnormal, describe: ________________________
   ☐ MUGA
      Date of MUGA: ______________
      Left ventricular ejection fraction (LVEF): _____%
      Result: ☐ Normal  ☐ Abnormal, describe: ________________________
   ☐ Coronary artery angiogram
      Date of angiogram: ______________
      Result: ☐ Normal  ☐ Abnormal, describe: ________________________
   ☐ CT angiography
      Date of CT angiography: ______________
      Result: ☐ Normal  ☐ Abnormal, describe: ________________________
   ☐ Other test, specify: _______________________________________
      Date: _______________
      Result: ____________

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

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

   Indicate all testing completed; provide only most recent results which reflect the Veteran's 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

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<th>Right</th>
<th>5/5</th>
<th>4/5</th>
<th>3/5</th>
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<tr>
<td>Knee extension:</td>
<td>Right</td>
<td>5/5</td>
<td>4/5</td>
<td>3/5</td>
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<td>1/5</td>
<td>0/5</td>
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</table>

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
   Describe current symptoms: ______________________

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

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

a. Does the Veteran now have or has he or she ever had a meniscus (semilunar cartilage) condition?
   ☐ Yes  ☐ No
If yes, indicate severity and frequency of symptoms, and side affected:
   ☐ No symptoms  ☐ Right  ☐ Left  ☐ Both
   ☐ Meniscal dislocation  ☐ Right  ☐ Left  ☐ Both
   ☐ Meniscal tear  ☐ Right  ☐ Left  ☐ Both
   ☐ Frequent episodes of joint “locking”  ☐ Right  ☐ Left  ☐ Both
   ☐ Frequent episodes of joint pain  ☐ Right  ☐ Left  ☐ Both
   ☐ Frequent episodes of joint effusion  ☐ Right  ☐ Left  ☐ Both

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

c. Does the Veteran have any residual signs and/or symptoms due to a meniscectomy?
   ☐ Yes  ☐ No
   If yes, indicate side affected: ☐ Right  ☐ Left  ☐ Both
   Describe residuals: ______________________
13. Joint replacement and other surgical procedures
a. Has the Veteran had a total knee joint replacement?
   □ Yes  □ No
   If yes, indicate side and severity of residuals.
   □ Right knee
   Date of surgery: ___________________
   Residuals:
   □ None
   □ Intermediate degrees of residual weakness, pain or limitation of motion
   □ Chronic residuals consisting of severe painful motion or weakness
   □ Other, describe: ______________
   □ Left knee
   Date of surgery: ___________________
   Residuals:
   □ None
   □ Intermediate degrees of residual weakness, pain or limitation of motion
   □ Chronic residuals consisting of severe painful motion or weakness
   □ Other, describe: ______________

b. Has the Veteran had arthroscopic or other knee surgery not described above?
   □ Yes  □ No
   If yes, indicate side affected:  □ Right  □ Left  □ Both
   Date and type of surgery: ______________

c. Does the Veteran have any residual signs and/or symptoms due to arthroscopic or other knee surgery not described above?
   □ Yes  □ No
   If yes, indicate side affected:  □ Right  □ Left  □ Both
   Describe residuals: _________________________

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

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

15. Assistive devices
a. Does the Veteran use any assistive device(s) as a normal mode of locomotion, although occasional locomotion by other methods may be possible?
   □ Yes  □ No
   If yes, identify assistive device(s) used (check all that apply and indicate frequency):
   □ Wheelchair  Frequency of use: □ Occasional  □ Regular  □ Constant
   □ Brace(s)  Frequency of use: □ Occasional  □ Regular  □ Constant
   □ Crutches(es)  Frequency of use: □ Occasional  □ Regular  □ Constant
   □ Cane(s)  Frequency of use: □ Occasional  □ Regular  □ Constant
   □ Walker  Frequency of use: □ Occasional  □ Regular  □ Constant
   □ Other: ____________  Frequency of use: □ Occasional  □ Regular  □ Constant
b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition: ________________________________________________________

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

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

If yes, indicate extremity(ies) for which this applies:
☐ Right lower ☐ Left lower

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

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

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

If yes, is degenerative or traumatic arthritis documented?
☐ Yes ☐ No

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

b. Does the Veteran have x-ray evidence of patellar subluxation?
☐ Yes ☐ No

If yes, indicate affected side(s): ☐ Right ☐ Left ☐ Both

c. Are there any other significant diagnostic test findings and/or results?
☐ Yes ☐ No

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

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

☐ Yes ☐ No

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

19. Remarks, if any: ________________________________________________________________

Physician signature: ___________________________ Date: __________
Physician printed name: ___________________________
Medical license #: ___________ Physician address: ___________________________
Phone: __________________________ Fax: ___________________________

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
6.8. DBQ Medical Opinion

Name of Veteran: ________________________________ SSN: ___________________________

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

1. Definitions

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

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

2. Restatement of requested opinion

a. Insert requested opinion from general remarks: ____________________________________________

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

3. Evidence review

Was the Veteran’s VA claims file reviewed?

☐ Yes ☐ No

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

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

Complete only the sections below that you are asked to complete in the Medical Opinion DBQ request.
4. Medical opinion for direct service connection
Choose the statement that most closely approximates the etiology of the claimed condition.

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

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

c. Rationale:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

5. Medical opinion for secondary service connection

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

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

c. Rationale:
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

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

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

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

c. Rationale:
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
7. Medical opinion for aggravation of a nonservice connected condition by a service connected condition
a. Can you determine a baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition)?
☐ Yes  ☐ No
If “Yes” to question 7a, answer the following:
   i. Describe the baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition):
________________________________________________________________________
________________________________________________________________________
   ii. Provide the date and nature of the medical evidence used to provide the baseline: __________________
   iii. Is the current severity of the (claimed condition/diagnosis) greater than the baseline?
     ☐ Yes  ☐ No
     If yes, was the Veteran’s (claimed condition/diagnosis) at least as likely as not aggravated beyond its natural progression by (insert “service connected condition”)?
     ☐ Yes (provide rationale in section b.)
     ☐ No (provide rationale in section b.)
If “No” to question 7a, answer the following:
   i. Provide rationale as to why a baseline cannot be established (e.g. medical evidence is not sufficient to support a determination of a baseline level of severity): ____________________________________
   ii. Regardless of an established baseline, was the Veteran’s (claimed condition/diagnosis) at least as likely as not aggravated beyond its natural progression by (insert “service connected condition”)?
     ☐ Yes (provide rationale in section b.)
     ☐ No (provide rationale in section b.)

b. Provide rationale:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

8. Opinion regarding conflicting medical evidence
I have reviewed the conflicting medical evidence and am providing the following opinion:
________________________________________________________________________
________________________________________________________________________

Physician signature: ___________________________ Date: __________________
Physician printed name: ________________________ Phone: __________________
Medical license #: ___________ Physician address: _______________________

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
6.9. DBQ Scars Disfigurement

Name of patient/Veteran: ____________________________  SSN: ____________________

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

1. Diagnosis
   a. Does the Veteran have one or more scars anywhere on the body, or disfigurement of the head, face, or neck?
      □ Yes   □ No

   If yes, provide only diagnoses that pertain to scars anywhere on the body, or disfigurement of the head, face or neck:
   - Diagnosis #1: ____________________
     ICD code: ____________________
     Date of diagnosis: ______________

   - Diagnosis #2: ____________________
     ICD code: ____________________
     Date of diagnosis: ______________

   - Diagnosis #3: ____________________
     ICD code: ____________________
     Date of diagnosis: ______________

   If there are additional diagnoses that pertain to scars anywhere on the body, or disfigurement of the head, face, or neck due to scars or other causes, list using above format: _________

   b. Does the Veteran have any scars on the trunk or extremities (regions other than the head, face or neck)?
      □ Yes   □ No

      If yes, complete Section I

   c. Does the Veteran have any scars or disfigurement of the head, face or neck?
      □ Yes   □ No

      If yes, complete Section II

INSTRUCTIONS:
Provide all linear measurements in centimeters and area measurements in centimeters squared. For non-linear scars, measure the length and width at their widest points. After measuring the scars, use the summary sections to provide the combined approximate total area for all scars in each region.
If scars are too numerous to count (for example, multiple scattered shrapnel wound scars, acne scarring or pseudofolliculitis barbae), indicate “TNTC” and provide approximate combined total area.
Regardless of the answers to questions 1b and 1c, complete Section III.

NOTE: For VA purposes, superficial non-linear scars are those not associated with underlying soft tissue damage, while deep non-linear scars are associated with underlying soft tissue damage.
SECTION I: Scars of the trunk and extremities

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

   b. Are any of the scars of the trunk or extremities painful?
      - Yes
      - No
      If yes, specify number of painful scars: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 or more
      Describe the pain (if there are multiple painful scars, be sure to adequately identify which scars are painful):

   c. Are any of the scars of the trunk or extremities unstable, with frequent loss of covering of skin over the scar?
      - Yes
      - No
      If yes, specify number of unstable scars: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 or more
      Describe the loss of covering of skin over the scar (if there are multiple unstable scars, be sure to adequately identify which scars are unstable):

   d. Are any of the scars BOTH painful and unstable?
      - Yes
      - No
      If yes, specify number of scars that are both painful and unstable: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 or more
      Describe location of these scars:

   e. Are any of the scars of the trunk or extremities due to burns?
      - Yes
      - No
      If yes, identify each burn scar and state depth of original burn:
      Burn Scar #1:
      [ ] Full thickness or sub-dermal
      [ ] Deep partial thickness
      [ ] Less than deep partial thickness
      Burn Scar #2:
      [ ] Full thickness or sub-dermal
      [ ] Deep partial thickness
      [ ] Less than deep partial thickness

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

2. Physical exam for scars on the trunk and extremities

2-1. Details of scar findings for the trunk and extremities
   Indicate the anatomical regions affected and complete appropriate sections:
   a. Right upper extremity
      - Affected
      - Not affected
      Specify location of scars on right upper extremity and number them:
      Indicate types of scars and provide measurements (check all that apply):
      - Linear
        Length of each linear scar:
        Scar #1: __ cm Scar #2: __ cm Scar #3: __ cm Scar #4: __ cm Scar #5: __ cm If additional scars, list using same format:
      - Superficial non-linear
        Length and width of each superficial non-linear scar:
        Scar #1: __x__cm Scar #2: __x__cm Scar #3: __x__cm Scar #4: __x__cm Scar #5: __x__cm If additional scars, list using same format:
      - Deep non-linear
        Length and width of each deep non-linear scar:
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: __ cm  Scar #2: __ cm  Scar #3: __ cm  Scar #4: __ cm
Scar #5: __ cm  If additional scars, list using same format: ___________________

□ Deep non-linear
Length and width of each deep non-linear scar:
Scar #1: __ cm  Scar #2: __ cm  Scar #3: __ cm  Scar #4: __ cm
Scar #5: __ 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: __ cm  Scar #2: __ cm  Scar #3: __ cm  Scar #4: __ cm
Scar #5: __ cm  If additional scars, list using same format: ___________________

□ Deep non-linear
Length and width of each deep non-linear scar:
Scar #1: __ cm  Scar #2: __ cm  Scar #3: __ cm  Scar #4: __ cm
Scar #5: __ 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: __ cm  Scar #2: __ cm  Scar #3: __ cm  Scar #4: __ cm
Scar #5: __ cm  If additional scars, list using same format: ___________________

□ Deep non-linear
Length and width of each deep non-linear scar:
Scar #1: __ cm  Scar #2: __ cm  Scar #3: __ cm  Scar #4: __ cm
Scar #5: __ 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: ___________________
Scar #1: __ cm  Scar #2: __ cm  Scar #3: __ cm  Scar #4: __ cm
Scar #5: __ cm  If additional scars, list using same format: ______________

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

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

f. Posterior trunk
  □ Affected  □ Not affected
  Specify location of scars on posterior trunk and number them: _________________________
  Indicate types of scars and provide measurements (check all that apply):
  □ Linear
    Length of each linear scar:
    Scar #1: ___cm  Scar #2: ___cm  Scar #3: ___cm  Scar #4: ___cm
    Scar #5: ___cm  If additional scars, list using same format: ______________
  □ Superficial non-linear
    Length and width of each superficial non-linear scar:
    Scar #1: ___x__cm  Scar #2: ___x__cm  Scar #3: ___x__cm  Scar #4: ___x__cm
    Scar #5: ___x__cm  If additional scars, list using same format: ______________
  □ Deep non-linear
    Length and width of each deep non-linear scar:
    Scar #1: ___x__cm  Scar #2: ___x__cm  Scar #3: ___x__cm  Scar #4: ___x__cm
    Scar #5: ___x__cm  If additional scars, list using same format: ______________

2-2. Summary of nonlinear scar areas for the trunk and extremities
a. Superficial non-linear scars (check all that apply and provide approximate combined total area in centimeters squared for each affected anatomical region)
  □ None
  □ Right upper extremity:  Approximate total area: ___________ cm²
  □ Left upper extremity:  Approximate total area: ___________ cm²
  □ Right lower extremity:  Approximate total area: ___________ cm²
  □ Left lower extremity:  Approximate total area: ___________ cm²
  □ Anterior trunk:  Approximate total area: ___________ cm²
  □ Posterior trunk:  Approximate total area: ___________ cm²

b. Deep non-linear scars (check all that apply and provide approximate combined total area in centimeters squared for each affected anatomical region)
  □ None
  □ Right upper extremity:  Approximate total area: ___________ cm²
  □ Left upper extremity:  Approximate total area: ___________ cm²
  □ Right lower extremity:  Approximate total area: ___________ cm²
  □ Left lower extremity:  Approximate total area: ___________ cm²
  □ Anterior trunk:  Approximate total area: ___________ cm²
  □ Posterior trunk:  Approximate total area: ___________ cm²
SECTION II: Scars or other disfigurement of the head, face or neck

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

   b. Are any of the scars of the head, face, or neck painful?
      ☐ Yes ☐ No
      If yes, specify number of painful scars:  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5 or more
      Describe the pain (if there are multiple painful scars, be sure to adequately identify which scars are painful): ________________

   c. Are any of the scars of the head, face, or neck unstable, with frequent loss of covering of skin over the scar?
      ☐ Yes ☐ No
      If yes, specify number of unstable scars:  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5 or more
      Describe the loss of covering of skin over the scar (if there are multiple unstable scars, be sure to adequately identify which scars are unstable): ________________

   d. Are any of the scars of the head face or neck BOTH painful and unstable?
      ☐ Yes ☐ No
      If yes, specify number of scars that are both painful and unstable:  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5 or more
      Describe location of these scars; ________________

   e. Are any of the scars of the head, face, or neck due to burns?
      ☐ Yes ☐ No
      If yes, identify each burn scar and state depth of original burn:
      Burn Scar #1: ____________________________________________
      ☐ Full thickness or sub-dermal
      ☐ Deep partial thickness
      ☐ Less than deep partial thickness
      Burn Scar #2: ____________________________________________
      ☐ Full thickness or sub-dermal
      ☐ Deep partial thickness
      ☐ Less than deep partial thickness

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

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

2-1. Details of scar or disfigurement for the head, face, and neck
   a. Identify each scar or disfigurement and provide measurements:
      Scar/Disfigurement #1
      Indicate type of impairment: ☐ Scar ☐ Disfigurement
      Location of scar/disfigurement #1: _________________________
      Length and width (at widest part) of scar/disfigurement #1: __x__ cm

      Scar/Disfigurement #2
      Indicate type of impairment: ☐ Scar ☐ Disfigurement
      Location of scar/disfigurement #2: _________________________
      Length and width (at widest part) of scar/disfigurement #2: __x__ cm

      Scar/Disfigurement #3
      Indicate type of impairment: ☐ Scar ☐ Disfigurement
Location of scar/disfigurement #3: _________________________
Length and width (at widest part) of scar/disfigurement #3: __x__ cm

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

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

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

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

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

b. Is there elevation, depression, adherence to underlying tissue, or missing underlying soft tissue?
☐ Yes  ☐ No
If yes, check all that apply:
☐ Surface contour elevated on palpation
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1  ☐ Scar/Disfigurement #2  ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4  ☐ Scar/Disfigurement #5  Other: ____________
☐ Surface contour depressed on palpation
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1  ☐ Scar/Disfigurement #2  ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4  ☐ Scar/Disfigurement #5  Other: ____________
☐ Scar adherent to underlying tissue
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1  ☐ Scar/Disfigurement #2  ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4  ☐ Scar/Disfigurement #5  Other: ____________
☐ Underlying soft tissue missing
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1  ☐ Scar/Disfigurement #2  ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4  ☐ Scar/Disfigurement #5  Other: ____________

c. Is there abnormal pigmentation or texture of the head, face, or neck?
☐ Yes  ☐ No
If yes, check all that apply:
☐ Hypopigmentation
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1  ☐ Scar/Disfigurement #2  ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4  ☐ Scar/Disfigurement #5  Other: ____________
☐ Hyperpigmentation
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1  ☐ Scar/Disfigurement #2  ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4  ☐ Scar/Disfigurement #5  Other: ____________
☐ Induration and inflexibility
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1  ☐ Scar/Disfigurement #2  ☐ Scar/Disfigurement #3
  ☐ Scar/Disfigurement #4  ☐ Scar/Disfigurement #5  Other: ____________
☐ Abnormal texture
  If checked, identify each affected scar/disfigurement:
  ☐ Scar/Disfigurement #1  ☐ Scar/Disfigurement #2  ☐ Scar/Disfigurement #3
2-2. Summary of scars or other disfigurement of the head, face and neck

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

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

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

Is there gross distortion or asymmetry of facial features or visible or palpable tissue loss?
☐ Yes   ☐ No

If yes, indicate features affected (check all that apply):
- Nose
- Chin
- Forehead
- Cheeks
- Lips
- Eyes (including eyelids)
  - Tissue loss/distortion of eyelid: Side: Right  Left
  - Anatomical loss of eye: Side: Right  Left
- Ears (auricles)
  - 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

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
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
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
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: ________________

b. 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): ________________

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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
  Diagnosis: __________________ ICD code: __________ Date of diagnosis: ______________

☐ Exfoliative dermatitis (erythroderma)
  Diagnosis: __________________ 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
  Diagnosis: __________________ ICD code: __________ Date of diagnosis: ______________

☐ Erythema multiforme
  Diagnosis: __________________ ICD code: __________ Date of diagnosis: ______________

☐ Acne
  Diagnosis: __________________ ICD code: __________ Date of diagnosis: ______________

☐ Chloracne
  Diagnosis: __________________ ICD code: __________ Date of diagnosis: ______________

☐ Alopecia
  Diagnosis: __________________ ICD code: __________ Date of diagnosis: ______________

☐ Hyperhidrosis
  Diagnosis: __________________ ICD code: __________ Date of diagnosis: ______________

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

☐ Other skin condition
  Other diagnosis #1: __________________ ICD code: __________ Date of diagnosis: ______________
  Other diagnosis #2: __________________ ICD code: __________ Date of diagnosis: ______________
  Other diagnosis #3: __________________ ICD code: __________ Date of diagnosis: ______________

If there are additional diagnoses that pertain to the skin conditions, list using above format: ______________
2. **Medical History**
   a. Describe the history (including onset and course) of the Veteran’s skin conditions (brief summary):
      
      ______________________________________________________________________________________

   b. Do any of the Veteran’s skin conditions cause scarring or disfigurement of the head, face or neck?
      □ Yes  □ No
      If yes, indicate skin condition and describe scarring and/or disfigurement: ________________
      Also complete the Scars Questionnaire if appropriate.

   c. Does the Veteran have any benign or malignant skin neoplasms (including malignant melanoma)?
      □ Yes  □ No
      If yes, also complete the Tumors and Neoplasms Questionnaire.

   d. Does the Veteran have any systemic manifestations due to any skin diseases (such as fever, weight loss or hypoproteinemia associated with skin conditions such as erythroderma)?
      □ Yes  □ No
      If yes, describe: ________________
      Also complete additional Questionnaires if appropriate.

3. **Treatment**
   a. Has the Veteran been treated with oral or topical medications in the past 12 months for any skin condition?
      □ Yes  □ No
      If yes, check all that apply:
      - □ Systemic corticosteroids or other immunosuppressive medications
        If checked, list medication(s): ________________
        Specify condition medication used for: ___________________________________________________________________
        Total duration of medication use in past 12 months:
        □ < 6 weeks  □ 6 weeks or more, but not constant  □ Constant/near-constant
      - □ Antihistamines
        If checked, list medication(s): ________________
        Specify condition medication used for: ___________________________________________________________________
        Total duration of medication use in past 12 months:
        □ < 6 weeks  □ 6 weeks or more, but not constant  □ Constant/near-constant
      - □ Immunosuppressive retinoids
        If checked, list medication(s): ________________
        Specify condition medication used for: ___________________________________________________________________
        Total duration of medication use in past 12 months:
        □ < 6 weeks  □ 6 weeks or more, but not constant  □ Constant/near-constant
      - □ Sympathomimetics
        If checked, list medication(s): ________________
        Specify condition medication used for: ___________________________________________________________________
        Total duration of medication use in past 12 months:
        □ < 6 weeks  □ 6 weeks or more, but not constant  □ Constant/near-constant
      - □ Other oral medications
        If checked, list medication(s): ________________
        Specify condition medication used for: ___________________________________________________________________
        Total duration of medication use in past 12 months:
        □ < 6 weeks  □ 6 weeks or more, but not constant  □ Constant/near-constant
      - □ Topical corticosteroids
        If checked, list medication(s): ________________
        Specify condition medication used for: ___________________________________________________________________
        Total duration of medication use in past 12 months:
        □ < 6 weeks  □ 6 weeks or more, but not constant  □ Constant/near-constant
Other topical medications
If checked, list medication(s): ____________________
Specify condition medication used for: _________________________________
Total duration of medication use in past 12 months:
☐ < 6 weeks  ☐ 6 weeks or more, but not constant  ☐ Constant/near-constant

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

b. Has the Veteran had any treatments or procedures other than systemic or topical medications in the past 12 months for exfoliative dermatitis or papulosquamous disorders?
☐ Yes  ☐ No
If yes, check all that apply:
☐ PUVA (photo-chemotherapy with psoralen and ultraviolet A) treatment
   If checked, specify condition treated: _________________________________
   Date of most recent treatment: _________________________________
   Total duration of treatment in past 12 months:
   ☐ < 6 weeks  ☐ 6 weeks or more, but not constant  ☐ Constant/near-constant
☐ UVB (ultraviolet B phototherapy) treatment
   If checked, specify condition treated: _________________________________
   Date of most recent treatment: _________________________________
   Total duration of treatment in past 12 months:
   ☐ < 6 weeks  ☐ 6 weeks or more, but not constant  ☐ Constant/near-constant
☐ Electron beam therapy
   If checked, specify condition treated: _________________________________
   Date of most recent treatment: _________________________________
   Total duration of treatment in past 12 months:
   ☐ < 6 weeks  ☐ 6 weeks or more, but not constant  ☐ Constant/near-constant
☐ Intensive light therapy
   If checked, specify condition treated: _________________________________
   Date of most recent treatment: _________________________________
   Total duration of treatment in past 12 months:
   ☐ < 6 weeks  ☐ 6 weeks or more, but not constant  ☐ Constant/near-constant
☐ Other treatment
   Specify treatment: _________________________________
   Specify condition treated: _________________________________
   Date of most recent treatment: _________________________________
   Total duration of treatment in past 12 months:
   ☐ < 6 weeks  ☐ 6 weeks or more, but not constant  ☐ Constant/near-constant

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

Number of non-debilitating episodes in past 12 months:
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
Characteristics of non-debilitating episodes
☐ Occurred despite ongoing immunosuppressive therapy
☐ Required treatment with intermittent systemic immunosuppressive therapy
☐ Responded to treatment with antihistamines or sympathomimetics

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

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

☐ Dermatitis
  Total body area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%
  EXPOSED area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%

☐ Eczema
  Total body area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%
  EXPOSED area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%

☐ Bullous disorder
  Total body area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%
  EXPOSED area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%

☐ Psoriasis
  Total body area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%
  EXPOSED area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%

☐ Infections of the skin
  Total body area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%
  EXPOSED area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%

☐ Cutaneous manifestations of collagen-vascular disease
  Total body area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%
  EXPOSED area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%

☐ Papulosquamous disorder
  Total body area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%
  EXPOSED area ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%

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

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

6. Specific Skin Conditions
Indicate the Veteran's specific skin conditions and complete all applicable subsequent questions (check all that apply):
☐ Acne or Chloracne
If checked, indicate severity and location (check all that apply):
☐ Superficial acne (comedones, papules, pustules, superficial cysts) of any extent
☐ Deep acne (deep inflamed nodules and pus-filled cysts)
☐ Affects less than 40% of face and neck
☐ Affects 40% or more of face and neck
☐ Affects body areas other than face and neck
☐ Vitiligo
If checked, indicate areas affected by vitiligo:
  ☐ Exposed areas affected
  ☐ No exposed areas affected

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

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

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

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

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

b. Is the neoplasm
  ☐ Benign  ☐ Malignant

c. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?
  ☐ Yes  ☐ No; watchful waiting
If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):
  ☐ Treatment completed; currently in watchful waiting status
  ☐ Surgery
    If checked, describe: __________________________
    Date(s) of surgery: ________________
  ☐ Radiation therapy
    Date of most recent treatment: ________________
    Date of completion of treatment or anticipated date of completion: ________________
  ☐ Antineoplastic chemotherapy
    Date of most recent treatment: ________________
    Date of completion of treatment or anticipated date of completion: ________________  ________________
  ☐ Other therapeutic procedure
    If checked, describe procedure: __________________________
    Date of most recent procedure: ________________
  ☐ Other therapeutic treatment
    If checked, describe treatment:
    Date of completion of treatment or anticipated date of completion: ________________
d. Does the Veteran currently have any residual conditions or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?
  □ Yes  □ No
If yes, list residual conditions and complications (brief summary): ______________________

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

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

Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?
  □ Yes  □ No
If yes, describe: ____________________________________________

9. **Functional impact**

Do any of the Veteran’s skin conditions impact his or her ability to work?
  □ Yes  □ No
If yes, describe impact of each of the Veteran’s skin conditions, providing one or more examples: __________

10. **Remarks, if any:** ________________________________________________

Physician signature: ________________________________ Date: ___
Physician printed name: ________________________________
Medical license #: ___________ Physician address: ________________________________
Phone: __________________________ Fax: _____________________________

**NOTE:** VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
7. Software and Documentation Retrieval

7.1 Software

The VistA software is being distributed as a PackMan patch message through the National Patch Module (NPM). The KIDS build for this patch is DVBA*2.7*172.

7.2 User Documentation

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

```
download.vista.med.va.gov
```

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

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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