

Compensation and Pension Record Interchange (CAPRI)

CAPRI Compensation and Pension Worksheet Module (CPWM)

Templates and AMIE Worksheet Disability Benefits Questionnaires (DBQs)

Release Notes

Patch: DVBA\*2.7\*173

July 2011

Department of Veterans Affairs

Office of Enterprise Development

Management & Financial Systems

**Preface**

**Purpose of the Release Notes**

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

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

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# Purpose

The purpose of this document is to provide an overview of the enhancements specifically designed

for Patch DVBA\*2.7\*173.

Patch DVBA \*2.7\*173 (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs)

introduces enhancements and updates made to the AUTOMATED MED INFO EXCHANGE

(AMIE) V 2.7 package and the Compensation & Pension Record Interchange (CAPRI) application

in support of the new Compensation and Pension (C&P) Disability Benefits Questionnaires (DBQs).

# Overview

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

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

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

# Associated Remedy Tickets & New Service Requests

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

# Defects Fixes

There are no CAPRI DBQ Templates or AMIE – DBQ Worksheet defects fixes associated with

patch DVBA\*2.7\*173.

# Enhancements

This section provides an overview of the modifications and primary functionality that will be

delivered in Patch DVBA\*2.7\*173.

## CAPRI – DBQ Template Additions

This patch includes adding four new CAPRI DBQ Templates that are accessible through the

Compensation and Pension Worksheet Module (CPWM) of the CAPRI GUI application.

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

## CAPRI – DBQ Template Modifications

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

## AMIE–DBQ Worksheet Additions

VBAVACO has approved the following new AMIE –DBQ Worksheets that are accessible through

the Veterans Health Information Systems and Technology Architecture (VistA) AMIE software

package.

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

This patch implements the new content for the AMIE C&P Disability Benefit Questionnaire

worksheets, which are accessible through the VISTA AMIE software package.

## AMIE–DBQ Worksheet Modifications

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

# Disability Benefits Questionnaires (DBQs)

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

6.1. DBQ Amputations

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.  VA**

**will consider the information you provide on this questionnaire as part of their evaluation**

**in processing the Veteran’s claim.**

NOTE: If there is limited motion or instability in the joint above the amputation site, also complete

a Questionnaire for the specific joint. If there are associated muscle injuries, also complete the

Muscle Injury Questionnaire.

**1. Diagnosis**

Has the Veteran had any amputations?

Yes  No

If yes, provide only diagnoses that pertain to amputations:

Amputation #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of amputation: \_\_\_\_\_\_\_\_\_\_\_\_

Amputation #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of amputation: \_\_\_\_\_\_\_\_\_\_\_\_

Amputation #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of amputation: \_\_\_\_\_\_\_\_\_\_\_\_

If additional amputations exist, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical history**

a. Describe the history (including etiology and course) of each amputation listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Dominant hand:

Right  Left  Ambidextrous

**3. Amputation sites**

Indicate affected sites:

Upper extremities (not including fingers)

Fingers

Lower extremities (not including toes)

Toes

For all checked sites, complete the corresponding sections below.

**4.** **Upper extremities (not including fingers)**

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

Yes  No

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

Below insertion of deltoid

Right  Left  Both

Above insertion of deltoid

Right  Left  Both

Disarticulation

Right  Left  Both

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

Yes  No

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

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

Yes  No

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

Amputation below insertion of pronator teres

Right  Left  Both

Amputation above insertion of pronator teres

Right  Left  Both

**5.** **Fingers**

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

Yes  No

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

Amputation at the distal joint or through the distal phalanx

Right  Left  Both

Amputation at the metacarpophalangeal joint or through the proximal phalanx

Right  Left  Both

Amputation with metacarpal resection

Right  Left  Both

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

Yes  No

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

Amputation through the middle phalanx or at the distal joint

Right index finger  Left index finger  Both index fingers

Right long finger  Left long finger  Both long fingers

Right ring finger  Left ring finger  Both ring fingers

Right little finger  Left little finger  Both little fingers

Amputation without metacarpal resection, at the proximal interphalangeal joint or proximal thereto

Right index finger  Left index finger  Both index fingers

Right long finger  Left long finger  Both long fingers

Right ring finger  Left ring finger  Both ring fingers

Right little finger  Left little finger  Both little fingers

Amputation with metacarpal resection (more than one-half the bone lost)

Right index finger  Left index finger  Both index fingers

Right long finger  Left long finger  Both long fingers

Right ring finger  Left ring finger  Both ring fingers

Right little finger  Left little finger  Both little fingers

**6.** **Lower extremities (not including the toes)**

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

Yes  No

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

Amputation to the middle or lower third of thigh

Right  Left  Both

Amputation to the upper third of thigh

Right  Left  Both

Disarticulation with loss of extrinsic pelvic girdle muscles

Right  Left  Both

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

Yes  No

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

c. Does the Veteran have a below-knee amputation of the lower leg, including the forefoot?

Yes  No

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

Amputation of forefoot proximal to the metatarsal bones (more than 1/2 of metatarsal loss)

Right  Left  Both

Amputation between the forefoot and knee, permitting prosthesis

Right  Left  Both

Amputation not improvable by prosthesis controlled by natural knee action

Right  Left  Both

Amputation with defective stump and amputation to the thigh recommended

Right  Left  Both

d. Does the lower leg amputation site allow the use of a suitable prosthetic appliance?

Yes  No

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

**7.** **Toes**

Does the Veteran have an amputation of any toes?

Yes  No

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

Amputation of toes without removal of the metatarsal head

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

Right great toe  Left great toe  Both great toes

Right 2nd toe  Left 2nd toe  Both 2nd toes

Right 3rd toe  Left 3rd toe  Both 3rd toes

Right 4th toe  Left 4th toe  Both 4th toes

Right little toe  Left little toe  Both little toes

Amputation of toes with removal of the metatarsal head

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

Right great toe  Left great toe  Both great toes

Right 2nd toe  Left 2nd toe  Both 2nd toes

Right 3rd toe  Left 3rd toe  Both 3rd toes

Right 4th toe  Left 4th toe  Both 4th toes

Right little toe  Left little toe  Both little toes

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the

treatment of any conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater

than 39 square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

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

and/or symptoms related to any conditions listed in the Diagnosis section above?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Assistive devices**

a. Does the Veteran use any assistive devices as a normal mode of locomotion, although

occasional locomotion by other methods may be possible?

Yes  No

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

Wheelchair Frequency of use:  Occasional  Regular  Constant

Brace(s) Frequency of use:  Occasional  Regular  Constant

Crutch(es) Frequency of use:  Occasional  Regular  Constant

Cane(s) Frequency of use:  Occasional  Regular  Constant

Walker Frequency of use:  Occasional  Regular  Constant

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of use:  Occasional  Regular  Constant

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device

used for each condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. Diagnostic Testing**

NOTE: Imaging studies are not required to document amputations.

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

Yes  No

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

**11. Functional impact**

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

Yes  No

If yes, describe the impact of each of the Veteran’s amputations, providing one or more examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12. Remarks, if any:** ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if

necessary to complete VA’s review of the Veteran’s application.

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

## Veins)

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN: \_\_\_

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.  VA**

**will consider the information you provide on this questionnaire as part of their evaluation**

**in processing the Veteran’s claim.**

**1. Diagnosis**

Does the Veteran now have or has he/she ever had a vascular disease (arterial or venous)?

Yes  No

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

Diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**2. Medical history**

a. Describe the cause/onset of the Veteran’s current vascular condition(s) (brief summary)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Type of vascular disease condition: (Check all that apply)

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

Section II: Peripheral vascular disease, aneurysm of any large artery (other than aorta),

arteriosclerosis obliterans or thrombo-angiitis obliterans (Buerger’s Disease)

Section III: Aortic aneurysm

Section IV: Aneurysm of a small artery

Section V: Raynaud’s syndrome

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

If checked, complete appropriate Section I-VI.

Regardless of checked condition, complete Section VII.

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

Does the Veteran have varicose veins or post-phlebitic syndrome of any etiology?

Yes  No

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

Asymptomatic palpable varicose veins  Right  Left  Both

Asymptomatic visible varicose veins  Right  Left  Both

Aching and fatigue in leg after prolonged

standing or walking  Right  Left  Both

Symptoms relieved by elevation of extremity  Right  Left  Both

Symptoms relieved by compression hosiery  Right  Left  Both

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

Incipient stasis pigmentation or eczema  Right  Left  Both

Persistent stasis pigmentation or eczema  Right  Left  Both

Intermittent ulceration  Right  Left  Both

Intermittent edema of extremity  Right  Left  Both

Persistent edema that is incompletely relieved

by elevation of extremity  Right  Left  Both

Persistent edema  Right  Left  Both

Persistent subcutaneous induration  Right  Left  Both

Massive board-like edema  Right  Left  Both

Constant pain at rest  Right  Left  Both

**Section II: Peripheral vascular disease, aneurysm of any large artery (other than aorta),**

**arteriosclerosis obliterans or thrombo-angiitis obliterans (Buerger’s Disease)**

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

Peripheral vascular disease

Aneurysm of any large artery (other than aorta)

Arteriosclerosis obliterans

Thrombo-angiitis obliterans (Buerger’s Disease)

None of the above

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

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

Yes  No

If yes, type of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

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

Yes  No

If yes, type of procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

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

Claudication on walking more than 100 yards  Right  Left  Both

Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour

Right  Left  Both

Claudication on walking less than 25 yards on a level grade at 2 miles per hour

Right  Left  Both

Persistent coldness of the extremity  Right  Left  Both

Diminished peripheral pulses  Right  Left  Both

Ischemic limb pain at rest  Right  Left  Both

Trophic changes (thin skin, absence of hair, dystrophic nails)

Right  Left  Both

1 or more deep ischemic ulcers  Right  Left  Both

**Section III: Aortic aneurysm**

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

Yes  No

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

Yes  No

If yes, indicate type of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

b. Does the Veteran currently have an aortic aneurysm?

Yes  No

If yes, indicate severity:

5 centimeters or larger in diameter:  Yes  No

Symptomatic  Yes  No

Precludes exertion  Yes  No

c. Does the Veteran have any post-surgical residuals due to treatment for aortic aneurysm?

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If there are symptoms or post-surgical residuals, also complete appropriate

Questionnaire according to body system affected.)

**Section IV: Aneurysm of a small artery**

a. Has the Veteran been diagnosed with an aneurysm of a small artery?

Yes  No

If yes, has the Veteran had a surgical procedure for an aneurysm of a small artery?

Yes  No

If yes, indicate type of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

b. Does the Veteran currently have an aneurysm of a small artery?

Yes  No

If yes, is the condition symptomatic?

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also, complete appropriate Questionnaire according to body system affected.

c. Does the Veteran have any post-surgical residuals due to treatment for an aneurysm of a small

artery?

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also, complete appropriate Questionnaire according to body system affected.

**Section V: Raynaud’s syndrome**

a. Does the Veteran have Raynaud’s syndrome?

Yes  No

If yes, complete this section.

b. Does the Veteran have characteristic attacks?

Yes  No

If yes, indicate frequency of characteristic attacks:

Less than once a week

1 to 3 times a week

4 to 6 times a week

At least daily

NOTE: Characteristic attacks consist of sequential color changes of the digits of one or more

extremities lasting minutes to hours, sometimes with pain and paresthesias, and precipitated by

exposure to cold or by emotional upsets.

c. Does the Veteran have 2 or more digital ulcers?

Yes  No

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

Yes  No

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

a. Does the Veteran have arteriovenous (AV) fistula, angioneurotic edema or erythromelalgia?

Yes  No

If yes, complete this section.

b. Does the Veteran have a traumatic arteriovenous (AV) fistula?

Yes  No

If yes, complete the following:

1. Indicate site of traumatic AV fistula:

Right upper extremity  Right lower extremity  Left upper extremity

Left lower extremity  Other location, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Indicate findings:

Edema

Stasis dermatitis

Ulceration

Cellulitis

Enlarged heart

Wide pulse pressure

Tachycardia

High output heart failure

3. Is there more than one traumatic AV fistula?

Yes  No

If yes, provide location and findings for each:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Does the Veteran have angioneurotic edema?

Yes  No

If yes, indicate severity and frequency of characteristic attacks:

Without laryngeal involvement

With laryngeal involvement

Lasts 1 to 7 days

Lasts longer than 7 days

Occurs once a year or less

Occurs 1 to 2 times a year

Occurs 2 to 4 times a year

Occurs 5 to 8 times a year

Occurs more than 8 times a year

d. Does the Veteran have erythromelalgia?

Yes  No

NOTE: Characteristic attack of erythromelalgia consists of burning pain in the hands, feet or both,

usually bilateral and symmetrical, with increased skin temperature and redness, occurring at

warm ambient temperatures.

If yes, indicate severity and frequency of characteristic attacks:

Do not restrict most routine daily activities

Restrict most routine daily activities

Occur less than 3 times a week

Occur at least 3 times a week

Occur daily

Occur more than once a day

Last an average of more than 2 hours each

Respond to treatment

Respond poorly to treatment

**Section VII: Miscellaneous Issues**

**1. Amputations**

Has the Veteran had an amputation of an extremity due to a vascular condition?

Yes  No

If yes, also complete Amputations Questionnaire

**2. Assistive devices**

a. Does the Veteran use any assistive device(s) as a normal mode of locomotion, although

occasional locomotion by other methods may be possible?

Yes  No

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

Wheelchair Frequency of use:  Occasional  Regular  Constant

Brace(s) Frequency of use:  Occasional  Regular  Constant

Crutch(es) Frequency of use:  Occasional  Regular  Constant

Cane(s) Frequency of use:  Occasional  Regular  Constant

Walker Frequency of use:  Occasional  Regular  Constant

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of use:  Occasional  Regular  Constant

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device

used for each condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Remaining effective function of the extremities**

Due to a vascular condition, is there functional impairment of an extremity such that no effective

function remains other than that which would be equally well served by an amputation with

prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions

for the lower extremity include balance and propulsion, etc.)

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

No

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

Right upper  Left upper  Right lower  Left lower

For each checked extremity, describe loss of effective function, identify the condition causing

loss of function, and provide specific examples (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the

treatment of any conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars 39

square cm (6 square inches) or greater?

Yes  No

If yes, also complete a Scars Questionnaire.

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

or symptoms related to the conditions listed in the Diagnosis section above?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Diagnostic testing**

a. Has ankle/brachial index testing been performed?

Yes  No  Unable to perform, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, provide most recent results:

Right ankle/brachial index: \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Left ankle/brachial index: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: An ankle/brachial index is required for peripheral vascular disease or aneurysm of any

large artery (other than aorta), arteriosclerosis obliterans or thrombo-angiitis obliterans (Buerger’s

disease) if not of record, or if there has been an intervening change in the Veteran’s peripheral

vascular condition.

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

Yes  No

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

**6. Functional impact**

Does the Veteran’s vascular condition(s) impact his or her ability to work?

Yes  No

If yes, describe impact of each of the Veteran’s vascular condition, providing one or more examples:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Remarks, if any:** ­­­­­­­­­­­­­­­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if

necessary to complete VA’s review of the Veteran’s application.

## 6.3. DBQ Elbow and Forearm Conditions

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.  VA**

**will consider the information you provide on this questionnaire as part of their evaluation**

**in processing the Veteran’s claim.**

**1. Diagnosis**

Does the Veteran now have or has he/she ever had an elbow or forearm condition?

Yes  No

If yes, provide only diagnoses that pertain to elbow and forearm conditions:

Diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

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

**2. Medical history**

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

b. Dominant hand:

Right  Left  Ambidextrous

**3. Flare-ups**

Does the Veteran report that flare-ups impact the function of the elbow and/or forearm?

Yes  No

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

**4. Initial range of motion (ROM) measurements**

MeasureROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the

measurements, document the point at which painful motion begins, evidenced by visible behavior such as

facial expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use

testing must be included in all joint exams. The VA has determined that 3 repetitions of ROM (at a minimum)

can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM

after 3 repetitions. Report post-test measurements in section 5.

a. Right elbow flexion

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

0 5 10 15 20 25 30 35 40

45 50 55 60 65 70 75 80 85

90 95 100 105 110 115 120 125 130

135 140 145 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40

45 50 55 60 65 70 75 80 85

90 95 100 105 110 115 120 125 130

135 140 145 or greater

b. Right elbow extension

Select where extension ends:

0 or any degree of hyperextension (no limitation of extension)

Unable to fully extend; extension ends at:

5 10 15 20 25 30 35 40

45 50 55 60 65 70 75 80 85

90 95 100 105 110 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 or any degree of hyperextension (no limitation of extension)

Unable to fully extend; extension ends at:

5 10 15 20 25 30 35 40

45 50 55 60 65 70 75 80 85

90 95 100 105 110 or greater

c. Left elbow flexion

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

0 5 10 15 20 25 30 35 40

45 50 55 60 65 70 75 80 85

90 95 100 105 110 115 120 125 130

135 140 145 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40

45 50 55 60 65 70 75 80 85

90 95 100 105 110 115 120 125 130

135 140 145 or greater

d. Left elbow extension

Select where extension ends:

0 or any degree of hyperextension (no limitation of extension)

Unable to fully extend; extension ends at:

5 10 15 20 25 30 35 40

45 50 55 60 65 70 75 80 85

90 95 100 105 110 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 or any degree of hyperextension (no limitation of extension)

Unable to fully extend; extension ends at:

5 10 15 20 25 30 35 40

45 50 55 60 65 70 75 80 85

90 95 100 105 110 or greater

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

reasons other than an elbow condition, such as age, body habitus, neurologic disease), explain: \_\_\_\_\_\_

**5. ROM measurements after repetitive use testing**

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?

Yes  No If unable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Veteran is unable to perform repetitive-use testing, skip to section 6.

If Veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions:

b. Right elbow post-test ROM

Select where post-test flexion ends:

0 5 10 15 20 25 30 35 40

45 50 55 60 65 70 75 80 85

90 95 100 105 110 115 120 125 130

135 140 145 or greater

Select where post-test extension ends:

0 or any degree of hyperextension (no limitation of extension)

Unable to fully extend; extension ends at:

5 10 15 20 25 30 35 40

45 50 55 60 65 70 75 80 85

90 95 100 105 110 or greater

c. Left elbow post-test ROM

Select where post-test flexion ends:

0 5 10 15 20 25 30 35 40

45 50 55 60 65 70 75 80 85

90 95 100 105 110 115 120 125 130

135 140 145 or greater

Select where post-test extension ends:

0 or any degree of hyperextension (no limitation of extension)

Unable to fully extend; extension ends at:

5 10 15 20 25 30 35 40 45 50 55 60 65 70

75 80 85 90 95 100 105 110 or greater

**6. Functional loss and additional limitation in ROM**

The following section addresses reasons for functional loss, if present, and additional loss of ROM after

repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working

movements of the body with normal excursion, strength, speed, coordination and/or endurance.

a. Does the Veteran have additional limitation in ROM of the elbow and forearm following repetitive-use testing?

Yes  No

b. Does the Veteran have any functional loss and/or functional impairment of the elbow and forearm?

Yes  No

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

and forearm after repetitive use, indicate the contributing factors of disability below (check all that apply and

indicate side affected):

No functional loss for right upper extremity

No functional loss for left upper extremity

Less movement than normal  Right  Left  Both

More movement than normal  Right  Left  Both

Weakened movement  Right  Left  Both

Excess fatigability  Right  Left  Both

Incoordination, impaired ability to execute

skilled movements smoothly  Right  Left  Both

Pain on movement  Right  Left  Both

Swelling  Right  Left  Both

Deformity  Right  Left  Both

Atrophy of disuse  Right  Left  Both

**7. Pain (pain on palpation)**

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

forearm?

Yes  No

If yes, side affected:  Right  Left  Both

**8. Muscle strength testing**

Rate strength according to the following scale:

0/5 No muscle movement

1/5 Palpable or visible muscle contraction, but no joint movement

2/5 Active movement with gravity eliminated

3/5 Active movement against gravity

4/5 Active movement against some resistance

5/5 Normal strength

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

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

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

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

**9. Ankylosis**

Does the Veteran have ankylosis of the elbow?

Yes  No

If yes, indicate side and severity:

At an angle of more than 90 degrees  Right  Left  Both

At an angle between 90 and 70 degrees  Right  Left  Both

At an angle between 70 and 50 degrees  Right  Left  Both

At an angle of less than 50 degrees  Right  Left  Both

**10. Additional conditions:**

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

Yes  No

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

a.  Flail joint of the elbow

If checked, indicate side:  Right  Left  Both

b.  Intra-articular fracture (joint fracture) with marked varus or valgus deformity?

If checked, indicate side:  Right  Left  Both

c.  Intra-articular fracture (joint fracture) with ununited fracture of the head of the radius?

If checked, indicate side:  Right  Left  Both

d.  Impairment of supination or pronation

If checked, indicate severity and side

Supination limited to 30 degrees or less  Right  Left  Both

Limited pronation with motion lost beyond the last quarter  Right  Left  Both

of the arc; hand does not approach full pronation

Limited pronation with motion lost beyond the middle of the arc  Right  Left  Both

Hand is fixed near the middle of the arc or moderate pronation due to bone fusion

Right  Left  Both

Hand fixed in full pronation due to bone fusion  Right  Left  Both

Hand fixed in supination or hyperpronation due to bone fusion  Right  Left  Both

**11. Joint replacement and other surgical procedures**

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

Yes  No

If yes, indicate side and severity of residuals.

Right elbow

Date of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residuals:

None

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

Chronic residuals consisting of severe painful motion and/or weakness

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_

Left elbow

Date of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residuals:

None

Intermediate degrees of residual weakness, pain or limitation of motion

Chronic residuals consisting of severe painful motion or weakness

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

Yes  No

If yes, indicate side affected:  Right  Left  Both

Date and type of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

Yes  No

If yes, indicate side affected:  Right  Left  Both

If yes, describe residuals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any

conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39

square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

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

symptoms related to any conditions listed in the Diagnosis section above?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE:** In all forearm injuries, if there are impaired finger movements due to tendon, muscle or nerve injuries,

also complete the appropriate disability Questionnaire(s), such as the Hand, Peripheral Nerve and/or Muscle

Injuries Questionnaire.

**13. Remaining effective function of the extremities**

Due to the service-connected disabling condition(s), is there functional impairment of an extremity such that

no effective function remains other than that which would be equally well served by an amputation with

prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the

lower extremity include balance and propulsion, etc.)

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

No

If yes, indicate extremities for which this applies**:**

Right upper  Left upper

For each checked extremity, identify the condition causing loss of function, describe loss of effective

function and provide specific examples (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**14. Diagnostic Testing**

The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging

studies. Once such arthritis has been documented, no further imaging studies are required by VA, even if

arthritis has worsened.

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

Yes  No

If yes, is degenerative or traumatic arthritis documented?

Yes  No

If yes, indicate elbow:  Right  Left  Both

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

Yes  No

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

**15. Functional impact**

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

Yes  No

If yes describe the impact of each of the Veteran’s conditions providing one or more examples\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**16. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to

complete VA’s review of the Veteran’s application.

## 6.4. DBQ Flatfoot (Pes Planus)

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.  VA**

**will consider the information you provide on this questionnaire as part of their evaluation**

**in processing the Veteran’s claim.**

**1. Diagnosis**

Does the Veteran now have or has he/she ever had flatfoot (pes planus)?

Yes  No

If yes, provide only diagnoses that pertain to flatfoot:

Diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

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

If the Veteran has additional foot conditions other than flatfoot, (such as extreme tenderness on the plantar

surfaces of the feet indicating plantar fasciitis), complete the Foot Miscellaneous Questionnaire.

**2. Medical history**

Describe the history (including onset and course) of the Veteran’s current flatfoot condition (i.e., when did

flatfoot first become symptomatic?) (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Signs and symptoms**

Indicate all signs and symptoms that apply to the Veteran’s flatfoot condition, regardless of whether similar

signs and symptoms appear more than once in different sections.

a. Does the Veteran have pain on use of the feet?

Yes  No

If yes, indicate side affected:  Right  Left  Both

If yes, is the pain accentuated on use?

Yes  No

If yes, indicate side affected:  Right  Left  Both

b. Does the Veteran have pain on manipulation of the feet?

Yes  No

If yes, indicate side affected:  Right  Left  Both

If yes, is the pain accentuated on manipulation?

Yes  No

If yes, indicate side affected:  Right  Left  Both

c. Is there indication of swelling on use?

Yes  No

If yes, indicate side affected:  Right  Left  Both

d. Does the Veteran have characteristic calluses (or any calluses caused by the flatfoot condition)?

Yes  No

If yes, indicate side affected:  Right  Left  Both

e. Are the Veteran’s symptoms relieved by arch supports (or built up shoes or orthotics)?

Yes  No

If no, indicate side that remains symptomatic despite arch supports or orthotics:

Right  Left  Both

f. Does the Veteran have extreme tenderness of plantar surface of one or both feet?

Yes  No

If yes, indicate side affected:  Right  Left  Both

Is the tenderness improved by orthopedic shoes or appliances?

Yes  No

**4. Alignment and deformity**

a. Does the Veteran have decreased longitudinal arch height on weight-bearing?

Yes  No

If yes, indicate side affected :  Right  Left  Both

b. Is there objective evidence of marked deformity of the foot (pronation, abduction etc.)?

Yes  No

If yes, indicate side affected:  Right  Left  Both

c. Is there marked pronation of the foot?

Yes  No

If yes, indicate side affected:  Right  Left  Both

If yes, is the condition improved by orthopedic shoes or appliances?

Yes  No

d. Does the weight-bearing line fall over or medial to the great toe?

Yes  No

If yes, indicate side affected:  Right  Left  Both

e. Is there a lower extremity deformity other than pes planus, causing alteration of the weight bearing line?

Yes  No

If yes, indicate side affected:  Right  Left  Both

Describe lower extremity deformity other than pes planus causing alteration of the weight bearing line: \_\_\_\_\_\_\_\_\_\_\_\_

f. Does the Veteran have “inward” bowing of the Achilles’ tendon (i.e., hind foot valgus, with lateral deviation

of the heel)?

Yes  No

If yes, indicate side affected:  Right  Left  Both

g. Does the Veteran have marked inward displacement and severe spasm of the Achilles tendon (rigid

hindfoot) on manipulation?

Yes  No

If yes, indicate side affected:  Right  Left  Both

Is the marked inward displacement and severe spasm of the Achilles tendon improved by orthopedic

shoes or appliances?

Yes  No

If yes, indicate side improved by orthopedic shoes or appliances:  Right  Left  Both

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any

conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39

square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

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

symptoms related to any conditions listed in the Diagnosis section above?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Assistive devices**

a. Does the Veteran use any assistive devices (other than corrective shoes or orthotic inserts) as a normal mode of locomotion, although occasional locomotion by other methods may be possible?

Yes  No

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

Wheelchair Frequency of use:  Occasional  Regular  Constant

Brace(s) Frequency of use:  Occasional  Regular  Constant

Crutch(es) Frequency of use:  Occasional  Regular  Constant

Cane(s) Frequency of use:  Occasional  Regular  Constant

Walker Frequency of use:  Occasional  Regular  Constant

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of use:  Occasional  Regular  Constant

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

each condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Remaining effective function of the extremities**

Due to the Veteran’s flatfoot condition, is there functional impairment of an extremity such that no effective

function remains other than that which would be equally well served by an amputation with prosthesis?

(Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity

include balance and propulsion, etc.)

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

No

If yes, indicate extremities for which this applies:

Right lower  Left lower

Identify the condition causing loss of function, describe loss of effective function and provide specific

examples (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Diagnostic Testing**

NOTE: Plain or weight-bearing foot x-rays are not required to make the diagnosis of flatfoot. The diagnosis of

degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such

arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

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

Yes  No

If yes, is degenerative or traumatic arthritis documented?

Yes  No

If yes, indicate foot:  Right  Left  Both

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

Yes  No

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

**9. Functional impact**

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

Yes  No

If yes describe the impact of each of the Veteran’s flatfoot conditions providing one or more examples: \_\_\_\_

**10. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to

complete VA’s review of the Veteran’s application.

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

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.  VA**

**will consider the information you provide on this questionnaire as part of their evaluation**

**in processing the Veteran’s claim.**

**1. Diagnosis**

Does the Veteran now have or has he/she ever had a foot condition (other than flatfoot)?

Yes  No

If yes, indicate diagnosis/es: (check all that apply) and complete appropriate section(s).

Provide only diagnoses that pertain to foot conditions other than flatfoot:

Morton’s neuroma ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Metatarsalgia ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Hammer toes ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Hallux valgus ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Hallux rigidus ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Claw foot (pes cavus) ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Malunion/nonunion of tarsal/metatarsal bones ICD code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Foot injuries (specify): \_\_\_\_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_

Other foot conditions (specify): \_\_\_\_\_ ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

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

**2. Medical history**

Describe the history (including onset and course) of the Veteran’s current foot condition (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Morton’s neuroma (Morton’s disease) and metatarsalgia**

a. Does the Veteran have Morton’s neuroma?

Yes  No

If yes, indicate side affected:  Right  Left  Both

b. Does the Veteran have metatarsalgia?

Yes  No

If yes, indicate side affected:  Right  Left  Both

**4. Hammer toe**

Does the Veteran have hammer toes?

Yes  No

If yes, which toes are affected on each side?

Right:  None  Great toe  Second toe  Third toe  Fourth toe  Little toe

Left:  None  Great toe  Second toe  Third toe  Fourth toe  Little toe

**5. Hallux valgus**

Does the Veteran now have or has he/she ever had hallux valgus?

Yes  No

If yes, complete the following:

a. Does the Veteran have symptoms due to a hallux valgus condition?

Yes  No

If yes, indicate severity (check all that apply):

Mild or moderate symptoms

Side affected:  Right  Left  Both

Severe symptoms, with function equivalent to amputation of great toe

Side affected:  Right  Left  Both

b. Has the Veteran had surgery for hallux valgus?

Yes  No

If yes, indicate type of surgery and side affected:

Resection of metatarsal head

Date of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Metatarsal osteotomy/metatarsal head osteotomy (equivalent to metatarsal head resection) Date of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Other surgery for hallux valgus, describe: \_\_\_\_\_\_\_\_\_

Date of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

**6. Hallux rigidus**

Does the Veteran have hallux rigidus?

Yes  No

If yes, does the Veteran have symptoms due to hallux rigidus?

Yes  No

If yes, indicate severity (check all that apply):

Mild or moderate symptoms

Side affected:  Right  Left  Both

Severe symptoms, with function equivalent to amputation of great toe

Side affected:  Right  Left  Both

**7. Pes cavus (claw foot)**

Does the Veteran have acquired claw foot (pes cavus)?

Yes  No

If yes, complete the following:

a. Effect on toes due to pes cavus (check all that apply)

None  Right  Left  Both

Great toe dorsiflexed  Right  Left  Both

All toes tending to dorsiflexion  Right  Left  Both

All toes hammer toes  Right  Left  Both

Other, describe (if there is an effect on toes due to other etiology than pes cavus, indicate other etiology): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

None  Right  Left  Both

Definite tenderness under metatarsal heads  Right  Left  Both

Marked tenderness under metatarsal heads  Right  Left  Both

Very painful callosities  Right  Left  Both

Other, describe (if the Veteran has pain and tenderness due to other etiology

than pes cavus, indicate other etiology): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

None  Right  Left  Both

Shortened plantar fascia  Right  Left  Both

Marked contraction of plantar fascia with  Right  Left  Both

dropped forefoot

Other, describe (if there is an effect on plantar fascia due to other etiology

than pes cavus, indicate other etiology): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

None  Right  Left  Both

Some limitation of dorsiflexion at ankle  Right  Left  Both

Limitation of dorsiflexion at ankle to right angle  Right  Left  Both

Marked varus deformity  Right  Left  Both

Other, describe (if the Veteran has dorsiflexion and varus deformity due to other etiology

than pes cavus, indicate other etiology): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Malunion or nonunion of tarsal or metatarsal bones**

Does the Veteran have malunion or nonunion of tarsal or metatarsal bones?

Yes  No

Indicate severity and side affected:

Moderate  Right  Left  Both

Moderately severe  Right  Left  Both

Severe  Right  Left  Both

**9. Foot injuries**

Does the Veteran have any other foot injuries?

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, indicate severity and side affected:

Moderate  Right  Left  Both

Moderately severe  Right  Left  Both

Severe  Right  Left  Both

**10. Bilateral weak foot**

NOTE: For VA purposes, bilateral weak foot is a symptomatic condition secondary to many constitutional

conditions characterized by atrophy of the musculature, disturbed circulation and weakness.

Is there evidence of bilateral weak foot?

Yes  No

If yes, describe and report underlying condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any

conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39

square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

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

symptoms related to any conditions listed in the Diagnosis section above?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12. Assistive devices**

a. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional

locomotion by other methods may be possible?

Yes  No

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

Wheelchair Frequency of use:  Occasional  Regular  Constant

Brace(s) Frequency of use:  Occasional  Regular  Constant

Crutch(es) Frequency of use:  Occasional  Regular  Constant

Cane(s) Frequency of use:  Occasional  Regular  Constant

Walker Frequency of use:  Occasional  Regular  Constant

Other: \_\_\_\_\_\_\_\_Frequency of use:  Occasional  Regular  Constant

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

each condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13. Remaining effective function of the extremities**

Due to the Veteran’s foot condition, is there functional impairment of an extremity such that no effective

function remains other than that which would be equally well served by an amputation with prosthesis?

(Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity

include balance and propulsion, etc.)

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

No

If yes, indicate extremities for which this applies:

Right lower  Left lower

For each checked extremity, describe loss of effective function, identify the condition causing loss of

function, and provide specific examples (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**14. Diagnostic Testing**

The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging

studies. Once such arthritis has been documented, no further imaging studies are required by VA, even if

arthritis has worsened.

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

Yes  No

If yes, are there abnormal findings?

Yes  No

If yes, indicate findings:

Degenerative or traumatic arthritis

Foot:  Right  Left  Both

Is degenerative or traumatic arthritis documented in multiple joints of the same foot, including

thumb and fingers?

Yes  No

If yes, indicate hand:  Right  Left  Both

Other. Describe: \_\_\_\_\_\_\_\_\_\_

Foot:  Right  Left  Both

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

Yes  No

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

**15. Functional impact**

Does the Veteran’s foot condition impact his or her ability to work?

Yes  No

If yes, describe the impact of each of the Veteran’s foot conditions providing one or more examples: \_\_\_

**16. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to

complete VA’s review of the Veteran’s application.

## 6.6. DBQ Hand and Finger Conditions

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.  VA**

**will consider the information you provide on this questionnaire as part of their evaluation**

**in processing the Veteran’s claim.**

**1. Diagnosis**

Does the Veteran now have or has he/she ever had a hand or finger condition?

Yes  No

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

Diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

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

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s hand condition (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Dominant hand:

Right  Left  Ambidextrous

**3. Flare-ups**

Does the Veteran report that flare-ups impact the function of the hand?

Yes  No

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

**4. Initial range of motion (ROM) measurements**

MeasureROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the

measurements, document the point at which painful motion begins, evidenced by visible behavior such as

facial expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use

testing must be included in all joint exams. The VA has determined that 3 repetitions of ROM (at a minimum)

can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM

after 3 repetitions. Report post-test measurements in section 5.

a. Is there limitation of motion or evidence of painful motion for any fingers or thumbs?

Yes  No

If no, skip to section 5

If yes, indicate digits affected (check all that apply):

Right:  Thumb  Index finger  Long finger  Ring finger  Little finger

Left:  Thumb  Index finger  Long finger  Ring finger  Little finger

b. Ability to oppose thumb: Is there a gap between the thumb pad and the fingers?

Yes  No

If yes, indicate distance of gap and side affected:

Less than 1 inch (2.5 cm.)  Right  Left  Both

1 to 2 inches (2.5 to 5.1 cm.)  Right  Left  Both

More than 2 inches (5.1 cm.)  Right  Left  Both

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

Pain begins at gap of less than 1 inch (2.5 cm.)  Right  Left  Both

Pain begins at gap of 1 to 2 inches (2.5 to 5.1 cm.)  Right  Left  Both

Pain begins at gap of more than 2 inches (5.1 cm.)  Right  Left  Both

c. Finger flexion: Is there a gap between any fingertips and the proximal transverse crease of the palm or

evidence of painful motion in attempting to touch the palm with the fingertips?

Yes  No

If yes, indicate the gap:

Gap less than 1 inch (2.5 cm)

Indicate fingers affected (check all that apply):

Right:  Index finger  Long finger  Ring finger  Little finger

Left:  Index finger  Long finger  Ring finger  Little finger

Gap 1 inch (2.5 cm) or more

Indicate fingers affected (check all that apply):

Right:  Index finger  Long finger  Ring finger  Little finger

Left:  Index finger  Long finger  Ring finger  Little finger

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

Painful motion begins at a gap of less than 1 inch (2.5 cm)

Indicate fingers affected (check all that apply):

Right:  Index finger  Long finger  Ring finger  Little finger

Left:  Index finger  Long finger  Ring finger  Little finger

Painful motion begins at a gap of 1 inch (2.5 cm) or more

Indicate fingers affected (check all that apply):

Right:  Index finger  Long finger  Ring finger  Little finger

Left:  Index finger  Long finger  Ring finger  Little finger

d. Finger extension: Is there limitation of extension or evidence of painful motion for the index finger or long

finger?

Yes  No

If yes, indicate limitation of extension:

Extension limited by no more than 30 degrees (unable to extend finger fully, extension limited to

between 0 and 30 degrees of flexion)

Indicate fingers affected: (check all that apply)

Right:  Index finger  Long finger

Left:  Index finger  Long finger

Extension limited by more than 30 degrees (unable to extend finger fully, extension limited to 31

degrees or more of flexion)

Indicate fingers affected: (check all that apply)

Right:  Index finger  Long finger

Left:  Index finger  Long finger

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

Painful motion begins at extension of no more than 30 degrees (unable to extend finger fully, painful

extension begins between 0 and 30 degrees of flexion)

Indicate fingers affected: (check all that apply)

Right:  Index finger  Long finger

Left:  Index finger  Long finger

Painful motion begins at extension of more than 30 degrees (unable to extend finger fully, painful

extension begins at 31 degrees or more of flexion)

Indicate fingers affected: (check all that apply)

Right:  Index finger  Long finger

Left:  Index finger  Long finger

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

reasons other than a hand condition, such as age, body habitus, neurologic disease), explain: \_\_\_\_\_\_\_\_\_\_\_

**5. ROM measurements after repetitive use testing**

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?

Yes  No If unable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Veteran is unable to perform repetitive-use testing, skip to section 6.

If Veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions:

b. Is there additional limitation of motion for any fingers post-test?

Yes  No

If yes, indicate digit(s) affected: (check all that apply)

Right:  Thumb  Index finger  Long finger  Ring finger  Little finger

Left:  Thumb  Index finger  Long finger  Ring finger  Little finger

c. Ability to oppose thumb: Is there a gap between the thumb pad and the fingers post-test?

Yes  No

If yes, indicate distance of gap and side affected:

Less than 1 inch (2.5 cm.)  Right  Left  Both

1 to 2 inches (2.5 to 5.1 cm.)  Right  Left  Both

More than 2 inches (5.1 cm.)  Right  Left  Both

d. Finger flexion: Is there a gap between any fingertips and the proximal transverse crease of the palm in

attempting to touch the palm with the fingertips post-test?

Yes  No

If yes, indicate the gap:

Gap less than 1 inch (2.5 cm)

Indicate fingers affected (check all that apply):

Right:  Index finger  Long finger  Ring finger  Little finger

Left:  Index finger  Long finger  Ring finger  Little finger

Gap 1 inch (2.5 cm) or more

Indicate fingers affected (check all that apply):

Right:  Index finger  Long finger  Ring finger  Little finger

Left:  Index finger  Long finger  Ring finger  Little finger

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

Yes  No

If yes, indicate limitation of extension:

Extension limited by no more than 30 degrees (unable to extend finger fully, extension limited to

between 0 and 30 degrees of flexion)

Indicate fingers affected: (check all that apply)

Right:  Index finger  Long finger

Left:  Index finger  Long finger

Extension limited by more than 30 degrees (unable to extend finger fully, extension limited to 31

degrees or more of flexion)

Indicate fingers affected: (check all that apply)

Right:  Index finger  Long finger

Left:  Index finger  Long finger

**6. Functional loss and additional limitation of ROM**

The following section addresses reasons for functional loss, if present, and additional loss of ROM after

repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working

movements of the body with normal excursion, strength, speed, coordination and/or endurance.

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

Yes  No

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

testing?

Yes  No

c. If the Veteran has functional loss, functional impairment or additional limitation of ROM of any of the fingers

or thumbs after repetitive use, indicate the contributing factors of disability below (check all that apply; indicate

digit and side affected):

No functional loss for right hand, thumb or fingers

No functional loss for left hand, thumb or fingers

Less movement than normal

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

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

More movement than normal

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

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

Weakened movement

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

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

Excess fatigability

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

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

Incoordination, impaired ability to execute skilled movements smoothly

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

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

Pain on movement

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

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

Swelling

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

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

Deformity

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

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

Atrophy of disuse

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

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

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Pain (pain on palpation)**

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

and fingers

Yes  No

If yes, side affected:  Right  Left  Both

**8. Muscle strength testing**

Rate strength according to the following scale:

0/5 No muscle movement

1/5 Palpable or visible muscle contraction, but no joint movement

2/5 Active movement with gravity eliminated

3/5 Active movement against gravity

4/5 Active movement against some resistance

5/5 Normal strength

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

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

**9. Ankylosis**

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

Yes  No

If yes, check all that apply:

Right thumb:

Carpometacarpal joint ankylosis:

In extension  In full flexion  In rotation or angulation

Thumb is abducted and rotated so that the thumb pad faces the finger pads

Interphalangeal joint ankylosis:

In extension  In full flexion  In rotation or angulation

Thumb is abducted and rotated so that the thumb pad faces the finger pads

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

with the thumb attempting to oppose the fingers.

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

the thumb attempting to oppose the fingers.

Left thumb:

Carpometacarpal joint ankylosis:

In extension  In full flexion  In rotation or angulation

Thumb is abducted and rotated so that the thumb pad faces the finger pads

Interphalangeal joint ankylosis:

In extension  In full flexion  In rotation or angulation

Thumb is abducted and rotated so that the thumb pad faces the finger pads

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

with the thumb attempting to oppose the fingers.

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

the thumb attempting to oppose the fingers.

Right:  Index finger  Long finger  Ring finger  Little finger

Metacarpophalangeal joint ankylosis:

In extension  In full flexion  In rotation or angulation

Flexed to 30 degrees

Proximal interphalangeal joint ankylosis:

In extension  In full flexion  In rotation or angulation

Flexed to 30 degrees

There is a gap of more than two inches (5.1 cm.) between the fingertip(s) and the proximal

transverse crease of the palm, with the finger(s) flexed to the extent possible.

There is a gap of two inches (5.1 cm.) or less between the fingertip(s) and the proximal

transverse crease of the palm, with the finger(s) flexed to the extent possible.

Left:  Index finger  Long finger  Ring finger  Little finger

Metacarpophalangeal joint ankylosis:

In extension  In full flexion  In rotation or angulation

Flexed to 30 degrees

Proximal interphalangeal joint ankylosis:

In extension  In full flexion  In rotation or angulation

Flexed to 30 degrees

There is a gap of more than two inches (5.1 cm.) between the fingertip(s) and the proximal

transverse crease of the palm, with the finger(s) flexed to the extent possible.

There is a gap of two inches (5.1 cm.) or less between the fingertip(s) and the proximal

transverse crease of the palm, with the finger(s) flexed to the extent possible.

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

c. Does the ankylosis condition result in limitation of motion of other digits or interference with overall function

of the hand?

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any

conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39

square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

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

symptoms related to any conditions listed in the Diagnosis section above?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11. Assistive devices and remaining function of the extremities**

a. Does the Veteran use any assistive devices?

Yes  No

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

Brace(s) Frequency of use:  Occasional  Regular  Constant

Other: \_\_\_\_\_\_\_\_\_\_\_ Frequency of use:  Occasional  Regular  Constant

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

each condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12. Remaining effective function of the extremities**

Due to the Veteran’s hand, finger or thumb conditions, is there functional impairment of an extremity such that

no effective function remains other than that which would be equally well served by an amputation with

prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the

lower extremity include balance and propulsion, etc.)

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

No

If yes, indicate extremities for which this applies**:**

Right upper  Left upper

For each checked extremity, identify the condition causing loss of function, describe loss of effective

function and provide specific examples (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13. Diagnostic Testing**

The diagnosis of arthritis must be confirmed by imaging studies. Once arthritis has been documented, no

further imaging studies are required by VA, even if arthritis has worsened.

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

Yes  No

If yes, are there abnormal findings?

Yes  No

If yes, indicate findings:

Degenerative or traumatic arthritis

Hand:  Right  Left  Both

Is degenerative or traumatic arthritis documented in multiple joints of the same hand, including

thumb and fingers?

Yes  No

If yes, indicate hand:  Right  Left  Both

Other. Describe: \_\_\_\_\_\_\_\_\_\_

Hand:  Right  Left  Both

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

Yes  No

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

**14. Functional impact**

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

Yes  No

If yes, describe the impact of each of the Veteran’s hand, thumb and/or finger conditions, providing one or

more examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**15. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to

complete VA’s review of the Veteran’s application.

## 6.7. DBQ Hip and Thigh Conditions

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.  VA**

**will consider the information you provide on this questionnaire as part of their evaluation**

**in processing the Veteran’s claim.**

**1. Diagnosis**

Does the Veteran now have or has he/she ever had a hip and/or thigh condition?

Yes  No

If yes, provide only diagnoses that pertain to hip/thigh conditions:

Diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

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

**2. Medical history**

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

**3. Flare-ups**

Does the Veteran report that flare-ups impact the function of the hip and/or thigh?

Yes  No

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

**4. Initial range of motion (ROM) measurements**

MeasureROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the

measurements, document the point at which painful motion begins, evidenced by visible behavior such as

facial expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use

testing must be included in all joint exams. The VA has determined that 3 repetitions of ROM (at a minimum)

can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM

after 3 repetitions. Report post-test measurements in section 5.

a. Right hip flexion

Select where flexion ends (normal endpoint is 125 degrees):

0 5 10 15 20 25 30 35 40 45

50 55 60 65 70 75 80 85 90  95

100 105 110 115 120 125 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40 45

50 55 60 65 70 75 80 85 90  95

100 105 110 115 120 125 or greater

b. Right hip extension

Select where extension ends:

0  5  Greater than 5

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0  5  Greater than 5

Is abduction lost beyond 10 degrees?

Yes  No

Is adduction limited such that the Veteran cannot cross legs?

Yes  No

Is rotation limited such that the Veteran cannot toe-out more than 15 degrees?

Yes  No

c. Left hip flexion

Select where flexion ends (normal endpoint is 125 degrees):

0 5 10 15 20 25 30 35 40 45

50 55 60 65 70 75 80 85 90  95

100 105 110 115 120 125 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40 45

50 55 60 65 70 75 80 85 90  95

100 105 110 115 120 125 or greater

d. Left hip extension

Select where extension ends:

0  5  Greater than 5

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0  5  Greater than 5

Is abduction lost beyond 10 degrees?

Yes  No

Is adduction limited such that the Veteran cannot cross legs?

Yes  No

Is rotation limited such that the Veteran cannot toe-out more than 15 degrees?

Yes  No

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

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

**5. ROM measurements after repetitive use testing**

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?

Yes  No If unable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Veteran is unable to perform repetitive-use testing, skip to section 6.

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

b. Right hip post-test ROM

Select where post-test flexion ends:

0 5 10 15 20 25 30 35 40 45

50 55 60 65 70 75 80 85 90  95

100 105 110 115 120 125 or greater

Select where post-test extension ends:

0  5 or greater

Is post-test abduction lost beyond 10 degrees?

Yes  No

Is post-test adduction limited such that the Veteran cannot cross legs?

Yes  No

Is post-test rotation limited such that the Veteran cannot toe-out more than 15 degrees?

Yes  No

c. Left hip post-test ROM

Select where post-test flexion ends:

0 5 10 15 20 25 30 35 40 45

50 55 60 65 70 75 80 85 90  95

100 105 110 115 120 125 or greater

Select where post-test extension ends:

0  5 or greater

Is post-test abduction lost beyond 10 degrees?

Yes  No

Is post-test adduction limited such that the Veteran cannot cross legs?

Yes  No

Is post-test rotation limited such that the Veteran cannot toe-out more than 15 degrees?

Yes  No

**6. Functional loss and additional limitation in ROM**

The following section addresses reasons for functional loss, if present, and additional loss of ROM after

repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working

movements of the body with normal excursion, strength, speed, coordination and/or endurance.

a. Does the Veteran have additional limitation in ROM of the hip and thigh following repetitive-use testing?

Yes  No

b. Does the Veteran have any functional loss and/or functional impairment of the hip and thigh?

Yes  No

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

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

side affected):

No functional loss for right lower extremity

No functional loss for left lower extremity

Less movement than normal  Right  Left  Both

More movement than normal  Right  Left  Both

Weakened movement  Right  Left  Both

Excess fatigability  Right  Left  Both

Incoordination, impaired ability to  Right  Left  Both

execute skilled movements smoothly

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 or weight-bearing

**7. Pain (pain on palpation)**

Does the Veteran have localized tenderness or pain to palpation for joints/soft tissue of either hip?

Yes  No

If yes, side affected:  Right  Left  Both

**8. Muscle strength testing**

Rate strength according to the following scale:

0/5 No muscle movement

1/5 Palpable or visible muscle contraction, but no joint movement

2/5 Active movement with gravity eliminated

3/5 Active movement against gravity

4/5 Active movement against some resistance

5/5 Normal strength

Hip flexion: Right:  5/5  4/5  3/5  2/5  1/5  0/5

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

Hip abduction: Right:  5/5  4/5  3/5  2/5  1/5  0/5

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

Hip extension: Right:  5/5  4/5  3/5  2/5  1/5  0/5

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

**9. Ankylosis**

Does the Veteran have ankylosis of either hip joint?

Yes  No

If yes, indicate severity and side affected:

Favorable, in flexion at an angle between 20 and 40 degrees, and slight adduction or abduction

Right  Left  Both

Intermediate, between favorable and unfavorable

Right  Left  Both

Unfavorable, extremely unfavorable ankylosis, foot not reaching ground, crutches needed

Right  Left  Both

**10. Additional conditions**

Does the Veteran have malunion or nonunion of femur, flail hip joint or leg length discrepancy?

Yes  No

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

a.  Malunion or nonunion of the femur

If checked, indicate severity and side affected:

Malunion with slight hip disability  Right  Left  Both

Malunion with moderate hip disability  Right  Left  Both

Malunion with marked hip disability  Right  Left  Both

Fracture of surgical neck with false joint  Right  Left  Both

Fracture of shaft or neck (anatomical), resulting in  Right  Left  Both

nonunion without loose motion; weight-bearing preserved

with aid of a brace

Fracture of shaft or neck (anatomical), with nonunion  Right  Left  Both

with loose motion (spiral or oblique fracture)

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

Questionnaire.

b.  Flail hip joint

If checked, indicate hip affected:  Right  Left  Both

c.  Leg length discrepancy (shortening of any bones of the lower extremity)

If checked, provide length of each lower extremity in inches (to the nearest 1/4 inch) or centimeters,

measuring from the anterior superior iliac spine to the internal malleolus of the tibia.

Measurements: Right leg: \_\_\_\_\_\_\_\_\_  cm  inches

Left leg: \_\_\_\_\_\_\_\_\_\_\_  cm  inches

**11. Joint replacement and other surgical procedures**

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

Yes  No

If yes, indicate side and severity of residuals.

Right hip

Date of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residuals:

None

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

Chronic residuals consisting of severe painful motion and/or weakness

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_

Left hip

Date of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residuals:

None

Intermediate degrees of residual weakness, pain or limitation of motion

Chronic residuals consisting of severe painful motion or weakness

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

Yes  No

If yes, indicate side affected:  Right  Left  Both

Date and type of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

Yes  No

If yes, indicate side affected:  Right  Left  Both

If yes, describe residuals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any

conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39

square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

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

symptoms related to any conditions listed in the Diagnosis section above?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13. Assistive devices**

a. Does the Veteran use any assistive device(s) as a normal mode of

locomotion, although occasional locomotion by other methods may be possible?

Yes  No

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

Wheelchair Frequency of use:  Occasional  Regular  Constant

Brace(s) Frequency of use:  Occasional  Regular  Constant

Crutch(es) Frequency of use:  Occasional  Regular  Constant

Cane(s) Frequency of use:  Occasional  Regular  Constant

Walker Frequency of use:  Occasional  Regular  Constant

Other: \_\_\_\_\_\_\_\_\_\_ Frequency of use:  Occasional  Regular  Constant

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

each condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**14. Remaining effective function of the extremities**

Due to the Veteran’s hip and/or thigh condition(s), is there functional impairment of an extremity such that no

effective function remains other than that which would be equally well served by an amputation with

prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the

lower extremity include balance and propulsion, etc.)

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

No

If yes, indicate extremities for which this applies**:**

Right lower  Left lower

For each checked extremity, identify the condition causing loss of function, describe loss of effective

function and provide specific examples (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**15. Diagnostic Testing**

The diagnosis of degenerative arthritis (osteoarthritis) or traumatic

arthritis must be confirmed by imaging studies. Once such arthritis has

been documented, no further imaging studies are indicated, even if

arthritis has worsened.

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

Yes  No

If yes, is degenerative or traumatic arthritis documented?

Yes  No

If yes, indicate hip:  Right  Left  Both

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

Yes  No

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

**16. Functional impact**

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

Yes  No

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

**17. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional

examinations if necessary to complete VA’s review of the Veteran’s application.

6.8. DBQ Muscle Injuries

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.  VA**

**will consider the information you provide on this questionnaire as part of their evaluation**

**in processing the Veteran’s claim.**

**SECTION I: DIAGNOSIS**

Does the Veteran now have or has he/she ever been diagnosed with a muscle injury?

Yes  No

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

Diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

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

NOTE: If there are multiple muscle injuries, complete the assessment for all muscle injuries on this

Questionnaire, if possible. If unable to complete assessment for all muscle injuries on this Questionnaire,

also complete an additional Questionnaire for each additional injury.

If the Veteran has or has had a muscle injury that results in any conditions that are not covered in this

Questionnaire, also complete any other appropriate Questionnaires (e.g., if peripheral nerve injury also

exists due to the muscle injury, complete the Peripheral Nerves Questionnaire).

**SECTION II: HISTORY OF MUSCLE INJURY**

a. Does the Veteran have a penetrating muscle injury, such as a gunshot or shell fragment wound?

Yes  No

b. Does the Veteran have a non-penetrating muscle injury (such as a muscle strain, torn Achilles tendon or

torn quadriceps muscle)?

Yes  No

c. Describe the history (including onset and course) of the Veteran’s muscle injury: (brief summary): \_\_\_\_\_\_\_

d. Dominant hand

Right  Left Ambidextrous

**SECTION III: LOCATION OF MUSCLE INJURY**

NOTE: For VA purposes, muscles are classified into groups I-XXIII. In this section, indicate the location of the

Veteran’s muscle injuries by checking the muscle groups involved.

**1. Shoulder girdle and arm**

Does the Veteran now have or has he/she ever had an injury to a muscle group of the shoulder girdle or arm?

Yes  No

If yes, check muscle group(s) and side affected (check all that apply):

**Group I**: Extrinsic muscles of shoulder girdle: trapezius, levator scapulae, serratus magnus

Function: Upward rotation of scapula, elevation of arm above shoulder level

Side affected:  Right  Left  Both

**Group II:** Muscles of shoulder girdle: pectoralis major, latissimus dorsi and teres major, pectoralis

minor, rhomboid

Function: Depression of arm from vertical overhead to hanging at side, downward rotation of scapula,

forward and backward swing of arm

Side affected:  Right  Left  Both

**Group III:** Intrinsic muscles of shoulder girdle: pectoralis major, deltoid

Function: Elevation and abduction of arm to level of shoulder, forward and backward swing of arm.

Side affected:  Right  Left  Both

**Group IV:** Shoulder girdle muscles: supraspinatus, infraspinatus and teres minor, subscapularis,

coracobrachialis

Function: Stabilization of shoulder, abduction, rotation of arm

Side affected:  Right  Left  Both

**Group V:** Flexor muscles of elbow: biceps, brachialis, brachioradialis

Function: Flexion of elbow

Side affected:  Right  Left  Both

**Group VI:** Extensor muscles of elbow: triceps

Function: Extension of elbow

Side affected:  Right  Left  Both

**2. Forearm and hand**

Does the Veteran now have or has he/she ever had an injury to a muscle group of the forearm or hand?

Yes  No

If yes, check muscle group(s) and side affected (check all that apply):

**Group VII:** Muscles of forearm: Flexors of the wrist, fingers and thumb

Function: Flexion of wrist and fingers

Side affected:  Right  Left  Both

**Group VIII:** Muscles: Extensors of the wrist, fingers and thumb

Function: Extension of wrist, fingers and thumb

Side affected:  Right  Left  Both

**Group IX:** Intrinsic musclesof hand, including muscles in the thenar and hypothenar eminence,

lumbricales, dorsal and palmar interossei

Function: Intrinsic muscles of the hand assist in delicate manipulative movements

Side affected:  Right  Left  Both

**3. Foot and leg**

Does the Veteran now have or has he/she ever had an injury to a muscle group of the foot or leg?

Yes  No

If yes, check muscle group(s) and side affected (check all that apply):

**Group X:** Muscles of the foot: flexor digitorum brevis, abductor hallucis, abductor digiti minimi,

quadratus plantae, lumbricales, flexor hallucis brevis, adductor hallucis, flexor digiti minimi brevis, dorsal

and plantar interossei

Function: Movements of forefoot and toes, propulsion thrust in walking

Side affected:  Right  Left  Both

**Group XI:** Muscles of the foot, ankle and calf: gastrocnemius, soleus, tibalis posterior, peroneus

longus, peroneus brevis, flexor hallucis longus, flexor digitorum longus

Function: Propulsion, plantar flexion of foot, stabilization of arch, flexion of toes

Side affected:  Right  Left  Both

**Group XII:** Anterior muscles of the leg: tibalis anterior, extensor digitorum longus, extensor hallucis

longus, peroneus tertius

Function: Dorsiflexion, extension of toes, stabilization of arch

Side affected:  Right  Left  Both

**4. Pelvic girdle and thigh**

Does the Veteran now have or has he/she ever had an injury to a muscle group of the pelvic girdle or thigh?

Yes  No

If yes, check muscle group(s) and side affected (check all that apply):

**Group XIII:** Posterior thigh/hamstring muscles: biceps femoris, semimembranosus, semitendinosus

Function: Flexion of knee

Side affected:  Right  Left  Both

**Group XIV:** Anterior thigh muscles: sartorius, rectus femoris, quadriceps

Function: Extension of knee

Side affected:  Right  Left  Both

**Group XV:** Medial thigh muscles: adductor longus, adductor brevis, adductor magnus, gracilis

Function: Adduction of hip

Side affected:  Right  Left  Both

**Group XVI:** Pelvic girdle muscles: psoas, iliacus, pectineus

Function: Flexion of hip

Side affected:  Right  Left  Both

**Group XVII:** Pelvic girdle muscles: gluteus maximus, gluteus medius, gluteus minimus

Function: Extension of hip, abduction of thigh, postural support of body

Side affected:  Right  Left  Both

If checked, is there severe damage to muscle group XVII, such that Veteran is unable to rise from a

seated and stooped position and to maintain postural stability without assistance of any type?

Yes  No

**Group XVIII:** Pelvic girdle muscles: pyriformis, gemelli, obturator, quadratus femoris

Function: Outward rotation of thigh and stabilization of hip joint

Side affected:  Right  Left  Both

**5. Torso and neck**

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

Yes  No

If yes, check muscle group(s) and side or region affected (check all that apply):

**Group XIX:** Muscles of the abdominal wall: rectus abdominis, external oblique, internal oblique,

transversalis, quadratus lumborum

Function: Support of abdominal wall and lower thorax, flexion and lateral movement of spine

Side affected:  Right  Left  Both

**Group XX:** Spinal muscles: sacrospinalis, erector spinae

Function: Postural support of body, extension and lateral movement of the spine

Region affected:  Cervical  Thoracic  Lumbar

**Group XXI:** Muscles of respiration: thoracic muscle group.

Function: Respiration

Side affected:  Right  Left  Both

**Group XXII:** Muscles of the front of the neck: trapezius, sternocleidomastoid, hyoid muscles,

sternothyroid, digastric

Function: Rotation and flexion of the head, respiration, swallowing

Side affected:  Right  Left  Both

**Group XXIII:** Muscles of the side and back of the neck: suboccipital, lateral vertebral and anterior

vertebral muscles

Function: Movements of the head, fixation of shoulder movements

Side affected:  Right  Left  Both

**6. Additional conditions**

a. Does the Veteran have a history of rupture of the diaphragm with herniation?

Yes  No

If yes, also complete Hiatal Hernia Questionnaire.

b. Does the Veteran have a history of an extensive muscle hernia of any muscle, without other injury to the

muscle?  Yes  No

If yes, name muscle and describe current residuals \_\_\_\_\_\_.

c. Does the Veteran have a history of injury to the facial muscles?

Yes  No

If yes, complete the Questionnaire for Cranial Nerves, Scars, etc., as indicated by type of residuals.

If yes, is there interference to any extent with mastication?

Yes  No

**SECTION IV: MUSCLE INJURY EXAM**

**1. Scar, fascia and muscle findings**

a. Does the Veteran have any scar(s) associated with a muscle injury?

Yes  No

If yes, indicate severity of scar(s) caused by the muscle injury(ies) (check all that apply if there is more than

one area or type of scarring):

Minimal scar(s)

Entrance and (if present) exit scars are small or linear, indicating short track of missile through muscle

tissue

Entrance and (if present) exit scars indicating track of missile through one or more muscle groups

Ragged, depressed and adherent scars indicating wide damage to muscle groups in missile track

Adhesion of scar to one of the long bones, scapula, pelvic bones, sacrum or vertebrae, with epithelial

sealing over the bone rather than true skin covering in an area where bone is normally protected by

muscle

Other (including surgical scars related to muscle injuries shown above), also complete Scars

Questionnaire

b. Does the Veteran have any known fascial defects or evidence of fascial defects associated with any

muscle injuries?

Yes  No

If yes, indicate severity of fascial defect(s) caused by the muscle injury(ies) (check all that apply if there is

more than one area/type of fascial defect):

Some loss of deep fascial

Palpation shows loss of deep fascia

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Does the Veteran’s muscle injury(ies) affect muscle substance or function?

Yes  No

If yes, indicate effect of the muscle injury(ies) on muscle substance or function (check all that apply):

Some impairment of muscle tonus

Some loss of muscle substance

Soft flabby muscles in wound area

Muscles swell and harden abnormally in contraction

Induration or atrophy of an entire muscle following history of simple piercing by a projectile

Adaptive contraction of an opposing group of muscles

Visible or measurable atrophy

Atrophy of muscle groups not in the track of the missile, particularly of the trapezius and serratus in

wounds of the shoulder girdle

Tests of endurance or coordinated movements compared with the corresponding muscles of the

uninjured side indicate severe impairment of function

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Cardinal signs and symptoms of muscle disability**

Does the Veteran have any of the following signs and/or symptoms attributable to any muscle injuries?

Yes  No

If yes, check all that apply, and indicate side affected, muscle group and frequency/severity.

Loss of power

If checked, indicate side affected:  Right  Left  Both

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

Indicate frequency/severity:  Occasional  Consistent  Consistent at a more severe level

Weakness

If checked, indicate side affected:  Right  Left  Both

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

Indicate frequency/severity:  Occasional  Consistent  Consistent at a more severe level

Lowered threshold of fatigue

If checked, indicate side affected:  Right  Left  Both

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

Indicate frequency/severity:  Occasional  Consistent  Consistent at a more severe level

Fatigue-pain

If checked, indicate side affected:  Right  Left  Both

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

Indicate frequency/severity:  Occasional  Consistent  Consistent at a more severe level

Impairment of coordination

If checked, indicate side affected:  Right  Left  Both

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

Indicate frequency/severity:  Occasional  Consistent  Consistent at a more severe level

Uncertainty of movement

If checked, indicate side affected:  Right  Left  Both

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

Indicate frequency/severity:  Occasional  Consistent  Consistent at a more severe level

If further clarification is needed due to injuries of multiple muscle groups, describe which findings, signs

and/or symptoms are attributable to each muscle injury: \_\_\_\_\_\_\_\_\_

**3. Muscle strength testing**

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

Rate strength according to the following scale:

0/5 No muscle movement

1/5 Visible muscle movement, but no joint movement

2/5 No movement against gravity

3/5 No movement against resistance

4/5 Less than normal strength

5/5 Normal strength

Shoulder abduction (Group III) Right:  5/5  4/5  3/5  2/5  1/5  0/5

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

Elbow flexion (Group V) Right:  5/5  4/5  3/5  2/5  1/5  0/5

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

Elbow extension (Group VI) Right:  5/5  4/5  3/5  2/5  1/5  0/5

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

Wrist flexion (Group VII) Right:  5/5  4/5  3/5  2/5  1/5  0/5

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

Wrist extension (Group VIII) Right:  5/5  4/5  3/5  2/5  1/5  0/5

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

Hip flexion (Group XVI) Right:  5/5  4/5  3/5  2/5  1/5  0/5

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

Knee flexion (Group XIII) Right:  5/5  4/5  3/5  2/5  1/5  0/5

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

Knee extension (Group XIV) Right:  5/5  4/5  3/5  2/5  1/5  0/5

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

Ankle plantar flexion (Group XI) Right:  5/5  4/5  3/5  2/5  1/5  0/5

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

Ankle dorsiflexion (Group XII) Right:  5/5  4/5  3/5  2/5  1/5  0/5

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

If other movements/muscle groups were tested, specify: \_\_\_\_\_\_\_\_

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

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

Does the Veteran have muscle atrophy?

Yes  No

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

Indicate side affected:  Right  Left  Both

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

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

bulk:

Normal side: \_\_\_\_\_ cm. Atrophied side: \_\_\_\_\_ cm.

If muscle atrophy is present in more than one muscle group, provide location and measurements, using

the same format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION V: OTHER**

**1. Assistive devices**

a. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional

locomotion by other methods may be possible?

Yes  No

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

Wheelchair Frequency of use:  Occasional  Regular  Constant

Brace(s) Frequency of use:  Occasional  Regular  Constant

Crutch(es) Frequency of use:  Occasional  Regular  Constant

Cane(s) Frequency of use:  Occasional  Regular  Constant

Walker Frequency of use:  Occasional  Regular  Constant

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of use:  Occasional  Regular  Constant

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device

used for each condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Remaining effective function of the extremities**

Due to the Veteran’s muscle conditions, is there functional impairment of an extremity such that no effective

function remains other than that which would be equally well served by an amputation with prosthesis?

(Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity

include balance and propulsion, etc.)

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

No

If yes, indicate extremities for which this applies:

Right lower  Right upper  Left lower  Left upper

For each checked extremity, identify the condition causing loss of function, describe loss of effective

function and provide specific examples (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

symptoms?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Diagnostic Testing**

NOTE: If there is reason to believe there are retained metallic fragments in the muscle tissue, appropriate x-

rays are required to determine location of retained metallic fragments. Once retained metallic fragments have

been documented, further imaging studies are usually not indicated.

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

Yes  No

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

group?

Yes  No

If yes, indicate results:

X-ray evidence of retained shell fragment(s) and/or shrapnel

Location (specify muscle group I-XXIII, if possible): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

X-ray evidence of minute multiple scattered foreign bodies indicating intermuscular trauma and

explosive effect of the missile

Location (specify muscle group I-XXIII, if possible): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

c. Were electrodiagnostic tests done?

Yes  No

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

Yes  No

If yes, name affected muscle(s) \_\_\_\_\_\_\_\_\_\_\_\_.

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

Yes  No

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

**5. Functional impact**

Does the Veteran’s muscle injury(ies) impact his or her ability to work, such as resulting in inability to

keep up with work requirements due to muscle injury(ies)?

Yes  No

If yes, describe the impact of each of the Veteran’s muscle injuries providing one or more examples: \_\_\_\_\_

**6. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to

complete VA’s review of the Veteran’s application.

6.9. DBQ Temporomandibular Joint (TMJ) Conditions

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.  VA**

**will consider the information you provide on this questionnaire as part of their evaluation**

**in processing the Veteran’s claim.**

**1. Diagnosis**

Does the Veteran now have or has he/she ever had a temporomandibular joint condition?

Yes  No

If yes, provide only diagnoses that pertain to temporomandibular joint conditions:

Diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**2. Medical History**

a. Describe the history (including onset and course) of the Veteran’s temporomandibular joint condition (brief

summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Flare-ups**

Does the Veteran report that flare-ups impact the function of the temporomandibular joint?

Yes  No

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

**4. Initial range of motion (ROM) measurements**

MeasureROM. During the measurements, document the point at which painful motion begins, evidenced by

visible behavior such as facial expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use

testing must be included in all joint exams. The VA has determined that 3 repetitions of ROM (at a minimum)

can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM

after 3 repetitions. Report post-test measurements in section 5.

a. ROM for lateral excursion

Greater than 4 mm

0 to 4 mm

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

Greater than 4 mm

0 to 4 mm

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

Greater than 40 mm

31 to 40 mm

21 to 30 mm

11 to 20 mm

0 to 10 mm

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

Greater than 40 mm

31 to 40 mm

21 to 30 mm

11 to 20 mm

0 to 10 mm

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

reasons other than a temporomandibular joint condition, such as age, body habitus, neurologic disease),

explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. ROM measurement after repetitive use testing**

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?

Yes  No If unable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Veteran is unable to perform repetitive-use testing, skip to section 6.

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

b. Post-test ROM for lateral excursion

0 to 4 mm

Greater than 4 mm

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

Greater than 40 mm

31 to 40 mm

21 to 30 mm

11 to 20 mm

0 to 10 mm

**6. Functional loss and additional limitation in ROM**

The following section addresses reasons for functional loss, if present, and additional loss of ROM after

repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working

movements of the body with normal excursion, strength, speed, coordination and/or endurance.

a. Does the Veteran have additional limitation in ROM of either TMJ following repetitive-use testing?

Yes  No

b. Does the Veteran have any functional loss or functional impairment of either TMJ?

Yes  No

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

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

affected):

No functional loss for right TMJ

No functional loss for left TMJ

Less movement than normal  Right  Left  Both

More movement than normal  Right  Left  Both

Weakened movement  Right  Left  Both

Excess fatigability  Right  Left  Both

Incoordination, impaired ability to

execute skilled movements smoothly  Right  Left  Both

Pain on movement  Right  Left  Both

Swelling  Right  Left  Both

Deformity  Right  Left  Both

**7. Pain (pain on palpation) and crepitus**

a. Does the Veteran have localized tenderness or pain on palpation of joints or soft tissues of either TMJ?

Yes  No

If yes, side affected:  Right  Left  Both

b. Does the Veteran have clicking or crepitation of joints or soft tissues of either TMJ?

Yes  No

If yes, side affected:  Right  Left  Both

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any

conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39

square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

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

symptoms related to any conditions listed in the Diagnosis section above?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Diagnostic testing**

The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging

studies. Once such arthritis has been documented, no further imaging studies are required by VA, even if

arthritis has worsened.

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

Yes  No

If yes, is degenerative or traumatic arthritis documented?

Yes  No

If yes, side affected:  Right  Left  Both

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

Yes  No

If yes, side affected:  Right  Left  Both

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

**10. Functional impact**

Does the Veteran’s temporomandibular joint condition impact his or her ability to work?

Yes  No

If yes, describe the impact of each of the Veteran’s temporomandibular conditions, providing one or more

examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to

complete VA’s review of the Veteran’s application.

## 6.10. DBQ Wrist Conditions

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.  VA**

**will consider the information you provide on this questionnaire as part of their evaluation**

**in processing the Veteran’s claim.**

**1. Diagnosis**

Does the Veteran now have or has he/she ever had a wrist condition?

Yes  No

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

Diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

Diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side affected:  Right  Left  Both

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

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s current wrist condition(s) (brief

summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Dominant hand:

Right  Left  Ambidextrous

**3. Flare-ups**

Does the Veteran report that flare-ups impact the function of the wrist?

Yes  No

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

**4. Initial range of motion (ROM) measurements**

MeasureROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the

measurements, document the point at which painful motion begins, evidenced by visible behavior such as

facial expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use

testing must be included in all joint exams. The VA has determined that 3 repetitions of ROM (at a minimum)

can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM

after 3 repetitions. Report post-test measurements in section 5.

a. Right wrist palmar flexion

Select where palmar flexion ends (endpoint of palmar flexion is 80 degrees):

0 5 10 15 20 25 30 35 40 45 50

55 60 65 70 75 80 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40 45 50

55 60 65 70 or greater

b. Right wrist dorsiflexion (extension)

Select where dorsiflexion (extension) ends (endpoint of dorsiflexion (extension) is 70 degrees):

0 5 10 15 20 25 30 35 40 45 50

55 60 65 70 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40 45 50

55 60 65 70 or greater

c. Left wrist palmar flexion

Select where palmar flexion ends (endpoint of palmar flexion is 80 degrees):

0 5 10 15 20 25 30 35 40 45 50

55 60 65 70 75 80 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40 45 50

55 60 65 70 or greater

c. Left wrist dorsiflexion (extension)

Select where dorsiflexion (extension) ends (endpoint of dorsiflexion (extension) is 70 degrees):

0 5 10 15 20 25 30 35 40 45 50

55 60 65 70 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40 45 50

55 60 65 70 or greater

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

reasons other than a wrist condition, such as age, body habitus, neurologic disease), explain: \_\_\_\_\_\_

**5. ROM measurements after repetitive use testing**

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?

Yes  No If unable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Veteran is unable to perform repetitive-use testing, skip to section 6.

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

b. Right wrist post-test ROM

Select where palmar flexion ends:

0 5 10 15 20 25 30 35 40 45 50

55 60 65 70 75 80 or greater

Select where dorsiflexion (extension) ends:

0 5 10 15 20 25 30 35 40 45 50

55 60 65 70 or greater

c. Left wrist post-test ROM

Select where palmar flexion ends:

0 5 10 15 20 25 30 35 40 45 50

55 60 65 70 75 80 or greater

Select where dorsiflexion (extension) ends:

0 5 10 15 20 25 30 35 40 45 50

55 60 65 70 or greater

**6. Functional loss and additional limitation in ROM**

The following section addresses reasons for functional loss, if present, and additional loss of ROM after

repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working

movements of the body with normal excursion, strength, speed, coordination and/or endurance.

a. Does the Veteran have additional limitation in ROM of the wrist following repetitive-use testing?

Yes  No

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

Yes  No

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

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

affected):

No functional loss for right upper extremity

No functional loss for left upper extremity

Less movement than normal  Right  Left  Both

More movement than normal  Right  Left  Both

Weakened movement  Right  Left  Both

Excess fatigability  Right  Left  Both

Incoordination,  Right  Left  Both

(impaired ability to execute skilled movements smoothly)

Pain on movement  Right  Left  Both

Swelling  Right  Left  Both

Deformity  Right  Left  Both

Atrophy of disuse  Right  Left  Both

**7. Pain (pain on palpation)**

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

Yes  No

If yes, side affected:  Right  Left  Both

**8. Muscle strength testing**

Rate strength according to the following scale:

0/5 No muscle movement

1/5 Palpable or visible muscle contraction, but no joint movement

2/5 Active movement with gravity eliminated

3/5 Active movement against gravity

4/5 Active movement against some resistance

5/5 Normal strength

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

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

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

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

**9. Ankylosis**

Does the Veteran have ankylosis of either wrist joint?

Yes  No

If yes, indicate severity and side affected:

Extremely unfavorable  Right  Left  Both

Unfavorable, with ulnar or radial deviation  Right  Left  Both

Unfavorable, in any degree of palmar flexion  Right  Left  Both

Any other unfavorable position  Right  Left  Both

Favorable in 20º to 30º dorsiflexion  Right  Left  Both

**10. Joint replacement and/or other surgical procedures**

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

Yes  No

If yes, indicate side and severity of residuals.

Right wrist

Date of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residuals:

None

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

Chronic residuals consisting of severe painful motion and/or weakness

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_

Left wrist

Date of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residuals:

None

Intermediate degrees of residual weakness, pain or limitation of motion

Chronic residuals consisting of severe painful motion or weakness

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

Yes  No

If yes, indicate side affected:  Right  Left  Both

Date and type of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

Yes  No

If yes, indicate side affected:  Right  Left  Both

If yes, describe residuals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions

or to the treatment of any conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39

square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

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

symptoms related to any conditions listed in the Diagnosis section above?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12. Remaining effective function of the extremities**

Due to the Veteran’s wrist conditions, is there functional impairment of an extremity such that no effective

function remains other than that which would be equally well served by an amputation with prosthesis?

(Functions of the upper extremity include grasping, manipulation, etc)

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

No

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

Right upper  Left upper

For each checked extremity, describe loss of effective function, identify the condition causing loss of function,

and provide specific examples (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13. Diagnostic Testing**

The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging

studies. Once such arthritis has been documented, no further imaging studies are indicated, even if arthritis

has worsened.

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

Yes  No

If yes, is degenerative or traumatic arthritis documented?

Yes  No

If yes, indicate wrist:  Right  Left  Both

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

Yes  No

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

**14. Functional impact**

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

Yes  No

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

**15. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to

complete VA’s review of the Veteran’s application.

## 7. Software and Documentation Retrieval

## 7.1 Software

The VistA software is being distributed as a PackMan patch message through the National Patch

Module (NPM). The KIDS build for this patch is DVBA\*2.7\*173.

## 7.2 User Documentation

The user documentation for this patch may be retrieved directly using FTP. The preferred method

is to FTP the files from:

**REDACTED**

This transmits the files from the first available FTP server. Sites may also elect to retrieve software

directly from a specific server as follows:

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

|  |  |  |
| --- | --- | --- |
| **File Name** | **Format** | **Description** |
| **DVBA\_27\_P173\_RN.PDF** | Binary | Release Notes |

## 7.3 Related Documents

The VistA Documentation Library (VDL) web site will also contain the DVBA\*2.7\*173 Release Notes.

This web site is usually updated within 1-3 days of the patch release date.

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

Content and/or changes to the DBQs are communicated by the Disability Examination Management Office

(DEMO) through:  <http://vbacodmoint1.vba.va.gov/bl/21/DBQ/default.asp>