

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

NAME OF CLAIMANT/VETERAN: [REDACTED]	CLAIMANT/VETERAN'S SOCIAL SECURITY NUMBER: [REDACTED]	DATE OF EXAMINATION: [REDACTED]
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NOTE TO EXAMINER: The Veteran 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.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA C&P EXAMINATION REQUEST? ☒ YES ☐ NO
HOW WAS THE EXAMINATION COMPLETED (CHECK ALL THAT APPLY)?

- ☒ In-person examination
☒ Records reviewed
☐ Examination via approved video telehealth
☐ Other, please specify in comments box

COMMENTS:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE THE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

- ☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.
☐ Review of available records in conjunction with an interview with the Veteran (without in-person or video telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

Evidence Reviewed (check all that apply):

- ☐ Not Requested ☐ No Records were Reviewed
☐ VA claims file (hard copy paper C-file)
☒ VA e-folder
☐ VA electronic health record
☐ Other, please specify in comments box

Evidence Comments:

DOMINANT HAND

DOMINANT HAND:

- ☒ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

SECTION I - DIAGNOSIS

NOTE: These are condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. LIST THE CLAIMED CONDITION(S) THAT PERTAIN TO THIS QUESTIONNAIRE:

Bilateral hand strain

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NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed Condition(s), explain your findings and reasons in the remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date determined through record review or reported history.

1B. SELECT DIAGNOSES ASSOCIATED WITH THE CLAIMED CONDITION(S) (Check all that apply):

☐ The Veteran does not have a current diagnosis associated with any claimed conditions listed above. (Explain your findings and reasons in the remarks section).

	Side affected:			ICD Code:	Date of diagnosis:	
	Right	Left	Both		Right	Left
<input type="checkbox"/> Dupuytren's contracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Trigger Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Swan neck deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Boutonniere deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Mallet finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Gamekeeper's thumb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Instability (chronic collateral ligament sprain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Volar plate injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> MCP/PIP joint prosthetic replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Ankylosis of digit joint(s), specify joint(s):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Degenerative arthritis, other than post-traumatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Arthritis, gonorrheal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Arthritis, pneumococcic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Arthritis, streptococcic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Arthritis, syphilitic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Arthritis, rheumatoid (multi-joint)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Post-traumatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Arthritis, typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Other specified forms of arthropathy (excluding gout) (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Osteoporosis, residuals of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Osteomalacia, residuals of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Bones, neoplasm, benign	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Osteitis deformans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Myositis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Heterotopic ossification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Tendinopathy (select one if known)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Tendinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Tendinosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Tenosynovitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Inflammatory other types (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

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1B. Continued	Side affected:			ICD Code:	Date of diagnosis:	
	Right	Left	Both		Right	Left
<input checked="" type="checkbox"/> Other (specify)						
Other diagnosis #1:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Other diagnosis #2:	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	M18	08/2024	08/2024
Bilateral hand osteoarthritis						
1C. If there are additional diagnoses that pertain to hand and finger conditions, list using above format:						

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S HAND, FINGER OR THUMB CONDITION (brief summary):

Onset Date:

2024

Details of Onset:

Service member reports he started to experience bilateral hand pain, which has continued.

Course since Onset:

Symptoms include bilateral hand pain, including pain in all the fingers resulting in difficulty gripping objects. Current treatment includes occupational therapy exercises PRN.

Current Symptoms:

Symptoms include bilateral hand pain, including pain in all the fingers resulting in difficulty gripping objects.

Current Treatment/Frequency:

occupational therapy exercises PRN

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2B. DOES THE VETERAN REPORT FLARE-UPS OF THE HAND, FINGER OR THUMB?

☐ YES ☒ NO

IF "YES," document the Veteran's description of the flare-ups he or she experiences, including the frequency, duration, characteristics, precipitating and alleviating factors, severity and/or extent of functional impairment he or she experiences during a flare-up of symptoms.

2C. DOES THE VETERAN REPORT HAVING ANY FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT OF THE JOINT OR EXTREMITY BEING EVALUATED ON THIS QUESTIONNAIRE, INCLUDING BUT NOT LIMITED TO AFTER REPEATED USE OVER TIME?

☒ YES ☐ NO

If "YES," document the Veteran's description of functional loss or functional impairment in his/her own words.

Right Hand:
difficulty gripping objects.

Left Hand:
difficulty gripping objects.

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION

There are several separate parameters requested for describing function of a joint. The question "Does this ROM contribute to a functional loss?" asks if there is a functional loss that can be ascribed to any documented loss of range of motion; and, unlike later questions, does not take into account the numerous other factors to be considered. Subsequent questions take into account additional factors such as pain, fatigue, weakness, lack of endurance, or incoordination. If there is pain noted on examination, it is important to understand whether or not that pain itself contributes to functional loss. Ideally, a claimant would be seen immediately after repetitive use over time or during a flare-up; however, this is not always feasible.

Information regarding joint function on repetitive use is broken up into two subsets. The first subset is based on observed repetitive use, and the second is based on functional loss associated with repeated use over time. The observed repetitive use section initially asks for objective findings after three or more repetitions of range of motion testing. The second subset provides a more global picture of functional loss associated with repetitive use over time. The latter takes into account medical probability of additional functional loss as a global view. This takes into account not only the objective findings noted on the examination, but also the subjective history provided by the claimant, as well as review of the available medical evidence.

Optimally, a description of any additional loss of function should be provided - such as what the degrees of range of motion would be opined to look like after repetitive use over time. However, when this is not feasible, an "as clear as possible" description of that loss should be provided. This same information (minus the three repetitions) is asked to be provided with regards to flare-ups.

Instructions to the examiner for gap measurement: The position of function of the hand is with the wrist dorsiflexed 20 to 30 degrees, the metacarpophalangeal and proximal interphalangeal joints flexed to 30 degrees, and the thumb (digit I) abducted and rotated so that the thumb pad faces the finger pads.

Limitation of motion of the thumb should be measured with the thumb abducted and rotated attempting to oppose the fingers. Measure the gap between the pads of the thumb and the finger pads, with the fingers considered a single unit.

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[illegible]

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For the index, long, ring, and little fingers (digits II, III, IV, and V), zero degrees of flexion represents the fingers fully extended, making a straight line with the rest of the hand. The position of function of the hand is with the wrist dorsiflexed 20 to 30 degrees, the metacarpophalangeal and proximal interphalangeal joints flexed to 30 degrees, and the thumb (digit I) abducted and rotated so that the thumb pad faces the finger pads. Only joints in these positions are considered to be in favorable position. For digits II through V, the metacarpophalangeal joint has a range of zero to 90 degrees of flexion, the proximal interphalangeal joint has a range of zero to 100 degrees of flexion, and the distal (terminal) interphalangeal joint has a range of zero to 70 or 80 degrees of flexion.

RIGHT HAND				LEFT HAND			
Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values.				Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values.			
INDEX FINGER	MCP	PIP	DIP	INDEX FINGER	MCP	PIP	DIP
Flexion endpoint	<u>90</u> 90 deg	<u>100</u> 100 deg	<u>70</u> 70 deg	Flexion endpoint	<u>90</u> 90 deg	<u>100</u> 100 deg	<u>70</u> 70 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg	Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg
LONG FINGER	MCP	PIP	DIP	LONG FINGER	MCP	PIP	DIP
Flexion endpoint	<u>90</u> 90 deg	<u>100</u> 100 deg	<u>70</u> 70 deg	Flexion endpoint	<u>90</u> 90 deg	<u>100</u> 100 deg	<u>70</u> 70 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg	Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg
RING FINGER	MCP	PIP	DIP	RING FINGER	MCP	PIP	DIP
Flexion endpoint	<u>90</u> 90 deg	<u>100</u> 100 deg	<u>70</u> 70 deg	Flexion endpoint	<u>90</u> 90 deg	<u>100</u> 100 deg	<u>70</u> 70 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg	Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg
LITTLE FINGER	MCP	PIP	DIP	LITTLE FINGER	MCP	PIP	DIP
Flexion endpoint	<u>90</u> 90 deg	<u>100</u> 100 deg	<u>70</u> 70 deg	Flexion endpoint	<u>90</u> 90 deg	<u>100</u> 100 deg	<u>70</u> 70 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>30</u> 0 deg	Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg
THUMB	MCP	IP		THUMB	MCP	IP	
Flexion endpoint	<u>100</u> 100 deg	<u>90</u> 90 deg		Flexion endpoint	<u>100</u> 100 deg	<u>90</u> 90 deg	
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg		Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	
Is there a gap between the pad of the thumb and fingers? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO _____ cm				Is there a gap between the pad of the thumb and fingers? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO _____ cm			
Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
Index Finger _____ cm Long Finger _____ cm				Index Finger _____ cm Long Finger _____ cm			
Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
If "YES," please explain. Include location, severity, and relationship to condition(s).				If "YES," please explain. Include location, severity, and relationship to condition(s).			
Description: Tenderness to palpation of interphalangeal joints of all fingers				Description: Tenderness to palpation of interphalangeal joints of all fingers			

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Location:
interphalangeal joints of all fingers

Severity:
moderate

Relationship to claimed condition:
Directly related to claimed condition

If noted on examination, which digit exhibited pain (select all that apply):

- ☒ Index finger
- ☒ Long finger
- ☒ Thumb
- ☒ Ring finger
- ☒ Little finger

If any limitation of motion or gap is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) (if different than above) in which limitation of motion or gap is specifically attributable to the factors identified and describe.

Location:
interphalangeal joints of all fingers

Severity:
moderate

Relationship to claimed condition:
Directly related to claimed condition

If noted on examination, which digit exhibited pain (select all that apply):

- ☒ Index finger
- ☒ Long finger
- ☒ Thumb
- ☒ Ring finger
- ☒ Little finger

If any limitation of motion or gap is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) (if different than above) in which limitation of motion or gap is specifically attributable to the factors identified and describe.

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<p>Is there a gap between the pad of the thumb and fingers on passive ROM?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO _____ cm</p> <p>Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion on passive ROM?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>Index Finger _____ cm Long Finger _____ cm</p> <p>Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue on passive ROM?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "YES," please explain. Include location, severity, and relationship to condition(s).</p> <p>Describe:</p> <p>Tenderness to palpation of interphalangeal joints of all fingers</p>	<p>Is there a gap between the pad of the thumb and fingers on passive ROM?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO _____ cm</p> <p>Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion on passive ROM?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>Index Finger _____ cm Long Finger _____ cm</p> <p>Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue on passive ROM?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "YES," please explain. Include location, severity, and relationship to condition(s).</p> <p>Describe:</p> <p>Tenderness to palpation of interphalangeal joints of all fingers</p>																																																																																																																																																								

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

<p>Location: interphalangeal joints of all fingers</p> <p>Severity: moderate</p> <p>Relationship to claimed condition: Directly related to claimed condition</p>	<p>Location: interphalangeal joints of all fingers</p> <p>Severity: moderate</p> <p>Relationship to claimed condition: Directly related to claimed condition</p>
<p>If noted on examination, which digit on passive ROM exhibited pain (select all that apply):</p> <div><input checked="" type="checkbox"/> Index finger</div> <div><input checked="" type="checkbox"/> Long finger</div> <div><input checked="" type="checkbox"/> Thumb</div> <div><input checked="" type="checkbox"/> Ring finger</div> <div><input checked="" type="checkbox"/> Little finger</div> <p>If any limitation of motion or gap is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) (if different than above) in which limitation of motion or gap is specifically attributable to the factors identified and describe.</p>	<p>If noted on examination, which digit on passive ROM exhibited pain (select all that apply):</p> <div><input checked="" type="checkbox"/> Index finger</div> <div><input checked="" type="checkbox"/> Long finger</div> <div><input checked="" type="checkbox"/> Thumb</div> <div><input checked="" type="checkbox"/> Ring finger</div> <div><input checked="" type="checkbox"/> Little finger</div> <p>If any limitation of motion or gap is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) (if different than above) in which limitation of motion or gap is specifically attributable to the factors identified and describe.</p>

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

Is there evidence of pain?
☒ YES ☐ NO
If "YES," check all that apply.
☒ Weight-bearing
☐ Nonweight-bearing
☒ Active motion
☒ Passive motion
☐ On rest/non-movement
☐ Does not result in/cause functional loss
☒ Causes functional loss (if checked describe in the comments box below)
Comments:
difficulty gripping objects.

Is there evidence of pain?
☒ YES ☐ NO
If "YES," check all that apply.
☒ Weight-bearing
☐ Nonweight-bearing
☒ Active motion
☒ Passive motion
☐ On rest/non-movement
☐ Does not result in/cause functional loss
☒ Causes functional loss (if checked describe in the comments box below)
Comments:
difficulty gripping objects.

RIGHT HAND

3B. OBSERVED REPETITIVE USE ROM
Is the Veteran able to perform repetitive-use testing with at least three repetitions?
☒ YES ☐ NO
If "NO," please explain:

Is there additional loss of function or range of motion after three repetitions?
☐ YES ☒ NO
If "YES," please respond to the following after the completion of the three repetitions:

INDEX FINGER	MCP	PIP	DIP
Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg
Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg
LONG FINGER	MCP	PIP	DIP
Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg
Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg
RING FINGER	MCP	PIP	DIP
Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg
Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg
LITTLE FINGER	MCP	PIP	DIP
Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg
Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg
THUMB	MCP	IP	
Flexion endpoint	_____ 100 deg	_____ 90 deg	
Extension endpoint	_____ 0 deg	_____ 0 deg	

LEFT HAND

3B. OBSERVED REPETITIVE USE ROM
Is the Veteran able to perform repetitive-use testing with at least three repetitions?
☒ YES ☐ NO
If "NO," please explain:

Is there additional loss of function or range of motion after three repetitions?
☐ YES ☒ NO
If "YES," please respond to the following after the completion of the three repetitions:

INDEX FINGER	MCP	PIP	DIP
Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg
Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg
LONG FINGER	MCP	PIP	DIP
Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg
Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg
RING FINGER	MCP	PIP	DIP
Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg
Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg
LITTLE FINGER	MCP	PIP	DIP
Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg
Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg
THUMB	MCP	IP	
Flexion endpoint	_____ 100 deg	_____ 90 deg	
Extension endpoint	_____ 0 deg	_____ 0 deg	

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

Is there a gap between the pad of the thumb and fingers after the completion of three repetitions?

☐ YES ☐ NO _____ cm

Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion after the completion of three repetitions?

☐ YES ☐ NO

Index Finger _____ cm Long Finger _____ cm

Select factors that cause this functional loss: (check all that apply)

- ☒ N/A
- ☐ Pain
- ☐ Fatigability
- ☐ Other
- ☐ Weakness
- ☐ Lack of endurance
- ☐ Incoordination

Is there a gap between the pad of the thumb and fingers after the completion of three repetitions?

☐ YES ☐ NO _____ cm

Is there a gap between the finger and proximal transverse crease of the hand on maximal finger flexion after the completion of three repetitions?

☐ YES ☐ NO

Index Finger _____ cm Long Finger _____ cm

Select factors that cause this functional loss: (check all that apply)

- ☒ N/A
- ☐ Pain
- ☐ Fatigability
- ☐ Other
- ☐ Weakness
- ☐ Lack of endurance
- ☐ Incoordination

Note: When pain is associated with movement, the examiner must give a statement on whether pain could significantly limit functional ability during flare-ups and/or after repeated use over time in terms of additional loss of range of motion or gap. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees or centimeters, as applicable) that reflect frequency, duration, and during flare-ups - even if not directly observed during a flare-up and/or after repeated use over time.

RIGHT HAND

3C. REPEATED USE OVER TIME

Is the Veteran being examined immediately after repeated use over time?

☐ YES ☒ NO

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time?

☒ YES ☐ NO

Select factors that cause this functional loss: (check all that apply)

- ☐ N/A
- ☒ Pain
- ☐ Fatigability
- ☐ Other
- ☐ Weakness
- ☐ Lack of endurance
- ☐ Incoordination

Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran.

INDEX FINGER	MCP	PIP	DIP
Flexion endpoint	<u>85</u> 90 deg	<u>95</u> 100 deg	<u>65</u> 70 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg

LONG FINGER	MCP	PIP	DIP
Flexion endpoint	<u>85</u> 90 deg	<u>95</u> 100 deg	<u>65</u> 70 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg

RING FINGER	MCP	PIP	DIP
Flexion endpoint	<u>85</u> 90 deg	<u>95</u> 100 deg	<u>65</u> 70 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg

LITTLE FINGER	MCP	PIP	DIP
Flexion endpoint	<u>85</u> 90 deg	<u>95</u> 100 deg	<u>65</u> 70 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>30</u> 0 deg

THUMB	MCP	IP
Flexion endpoint	<u>95</u> 100 deg	<u>85</u> 90 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg

LEFT HAND

3C. REPEATED USE OVER TIME

Is the Veteran being examined immediately after repeated use over time?

☐ YES ☒ NO

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time?

☒ YES ☐ NO

Select factors that cause this functional loss: (check all that apply)

- ☐ N/A
- ☒ Pain
- ☐ Fatigability
- ☐ Other
- ☐ Weakness
- ☐ Lack of endurance
- ☐ Incoordination

Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran.

INDEX FINGER	MCP	PIP	DIP
Flexion endpoint	<u>85</u> 90 deg	<u>95</u> 100 deg	<u>65</u> 70 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg

LONG FINGER	MCP	PIP	DIP
Flexion endpoint	<u>85</u> 90 deg	<u>95</u> 100 deg	<u>65</u> 70 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg

RING FINGER	MCP	PIP	DIP
Flexion endpoint	<u>85</u> 90 deg	<u>95</u> 100 deg	<u>65</u> 70 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg

LITTLE FINGER	MCP	PIP	DIP
Flexion endpoint	<u>85</u> 90 deg	<u>95</u> 100 deg	<u>65</u> 70 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg	<u>0</u> 0 deg

THUMB	MCP	IP
Flexion endpoint	<u>95</u> 100 deg	<u>85</u> 90 deg
Extension endpoint	<u>0</u> 0 deg	<u>0</u> 0 deg

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

Estimate the gap between the pad of the thumb and fingers immediately after repeated use over time.

0 cm

Estimate the gap between the finger and proximal transverse crease of the hand on maximal finger flexion immediately after repeated use over time.

Index Finger 0 cm Long Finger 0 cm

The examiner should provide the estimated range of motion and gap based on a review of all procurable information - to include the Veteran's statement on examination, case specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)

Estimate the gap between the pad of the thumb and fingers immediately after repeated use over time.

0 cm

Estimate the gap between the finger and proximal transverse crease of the hand on maximal finger flexion immediately after repeated use over time.

Index Finger 0 cm Long Finger 0 cm

The examiner should provide the estimated range of motion and gap based on a review of all procurable information - to include the Veteran's statement on examination, case specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)

RIGHT HAND

3D. FLARE-UPS

Is the examination being conducted during a flare-up?

☐ YES ☒ NO

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare-ups?

☐ YES ☒ NO

Select factors that cause this functional loss: (check all that apply)

- ☒ N/A
- ☐ Pain
- ☐ Fatigability
- ☐ Other
- ☐ Weakness
- ☐ Lack of endurance
- ☐ Incoordination

Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran.

INDEX FINGER	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg

LONG FINGER	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg

RING FINGER	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg

LEFT HAND

3D. FLARE-UPS

Is the examination being conducted during a flare-up?

☐ YES ☒ NO

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare-ups?

☐ YES ☒ NO

Select factors that cause this functional loss: (check all that apply)

- ☒ N/A
- ☐ Pain
- ☐ Fatigability
- ☐ Other
- ☐ Weakness
- ☐ Lack of endurance
- ☐ Incoordination

Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran.

INDEX FINGER	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg

LONG FINGER	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg

RING FINGER	MCP	PIP	DIP
Flexion endpoint	90 deg	100 deg	70 deg
Extension endpoint	0 deg	0 deg	0 deg

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

LITTLE FINGER	MCP	PIP	DIP
Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg
Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg

THUMB	MCP	IP
Flexion endpoint	_____ 100 deg	_____ 90 deg
Extension endpoint	_____ 0 deg	_____ 0 deg

Estimate the gap between the pad of the thumb and fingers during flare-ups.

_____ cm

Estimate the gap between the finger and proximal transverse crease of the hand on maximal finger flexion during flare-ups.

Index Finger _____ cm Long Finger _____ cm

The examiner should provide the estimated range of motion and gap based on a review of all procurable information - to include the Veteran's statement on examination, case specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)

The Veteran denies flare ups.

LITTLE FINGER	MCP	PIP	DIP
Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg
Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg

THUMB	MCP	IP
Flexion endpoint	_____ 100 deg	_____ 90 deg
Extension endpoint	_____ 0 deg	_____ 0 deg

Estimate the gap between the pad of the thumb and fingers during flare-ups.

_____ cm

Estimate the gap between the finger and proximal transverse crease of the hand on maximal finger flexion during flare-ups.

Index Finger _____ cm Long Finger _____ cm

The examiner should provide the estimated range of motion and gap based on a review of all procurable information - to include the Veteran's statement on examination, case specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)

The Veteran denies flare ups.

RIGHT HAND	
3E. ADDITIONAL FACTORS CONTRIBUTING TO DISABILITY	
In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:	
<input checked="" type="checkbox"/> None	<input type="checkbox"/> Interference with sitting
<input type="checkbox"/> Interference with standing	<input type="checkbox"/> Swelling
<input type="checkbox"/> Disturbance of locomotion	<input type="checkbox"/> Deformity
<input type="checkbox"/> Less movement than normal	<input type="checkbox"/> More movement than normal
<input type="checkbox"/> Weakened movement	<input type="checkbox"/> Atrophy of disuse
<input type="checkbox"/> Instability of station	<input type="checkbox"/> Other, describe:

LEFT HAND	
3E. ADDITIONAL FACTORS CONTRIBUTING TO DISABILITY	
In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:	
<input checked="" type="checkbox"/> None	<input type="checkbox"/> Interference with sitting
<input type="checkbox"/> Interference with standing	<input type="checkbox"/> Swelling
<input type="checkbox"/> Disturbance of locomotion	<input type="checkbox"/> Deformity
<input type="checkbox"/> Less movement than normal	<input type="checkbox"/> More movement than normal
<input type="checkbox"/> Weakened movement	<input type="checkbox"/> Atrophy of disuse
<input type="checkbox"/> Instability of station	<input type="checkbox"/> Other, describe:

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

Please describe additional contributing factors of disability:

Please describe additional contributing factors of disability:

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

Please describe additional contributing factors of disability *(continued)*

Please describe additional contributing factors of disability *(continued)*

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

SECTION IV - MUSCLE STRENGTH TESTING

4A. MUSCLE STRENGTH - 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

RIGHT HAND

Hand grip: 5 /5

LEFT HAND

Hand grip: 5 /5

4B. IF THE VETERAN HAS A REDUCTION IN MUSCLE STRENGTH, IS IT DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO

If "NO," provide rationale:

4B. IF THE VETERAN HAS A REDUCTION IN MUSCLE STRENGTH, IS IT DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO

If "NO," provide rationale:

4C. DOES THE VETERAN HAVE MUSCLE ATROPHY?

☐ YES ☒ NO

4D. IF "YES," IS THE MUSCLE ATROPHY DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO

If "NO," provide rationale:

4C. DOES THE VETERAN HAVE MUSCLE ATROPHY?

☐ YES ☒ NO

4D. IF "YES," IS THE MUSCLE ATROPHY DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO

If "NO," provide rationale:

4E. FOR ANY MUSCLE ATROPHY DUE TO A DIAGNOSIS LISTED IN SECTION 1, INDICATE SPECIFIC LOCATION OF ATROPHY, PROVIDING MEASUREMENTS IN CENTIMETERS OF NORMAL SIDE AND CORRESPONDING ATROPHIED SIDE, MEASURED AT MAXIMUM MUSCLE BULK.

☐ Right upper extremity (specify location of measurement):

Circumference of more normal side: _____ cm

Circumference of atrophied side: _____ cm

4E. FOR ANY MUSCLE ATROPHY DUE TO A DIAGNOSIS LISTED IN SECTION 1, INDICATE SPECIFIC LOCATION OF ATROPHY, PROVIDING MEASUREMENTS IN CENTIMETERS OF NORMAL SIDE AND CORRESPONDING ATROPHIED SIDE, MEASURED AT MAXIMUM MUSCLE BULK.

☐ Left upper extremity (specify location of measurement):

Circumference of more normal side: _____ cm

Circumference of atrophied side: _____ cm

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

SECTION V - ANKYLOSIS

NOTE: Ankylosis is the immobilization of a joint due to disease, injury, or surgical procedure.

RIGHT HAND	LEFT HAND
<p>5A. COMPLETE THIS SECTION IF THE VETERAN HAS ANKYLOSIS OF ANY THUMB OR FINGER JOINTS. INDICATE SEVERITY OF ANKYLOSIS AND SIDE AFFECTED (CHECK ALL THAT APPLY):</p> <p>INDEX FINGER</p> <p>MCP joint</p> <p><input checked="" type="checkbox"/> No ankylosis</p> <p><input type="checkbox"/> MCP ankylosis</p> <p>If ankylosed, is there rotation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, is there angulation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, what is the position of ankylosis?</p> <p><input type="checkbox"/> In extension <input type="checkbox"/> In full flexion</p> <p><input type="checkbox"/> Other, _____ degrees of flexion</p> <p>PIP joint</p> <p><input checked="" type="checkbox"/> No ankylosis</p> <p><input type="checkbox"/> PIP ankylosis</p> <p>If ankylosed, is there rotation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, is there angulation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, what is the position of ankylosis?</p> <p><input type="checkbox"/> In extension <input type="checkbox"/> In full flexion</p> <p><input type="checkbox"/> Other, _____ degrees of flexion</p>	<p>5A. COMPLETE THIS SECTION IF THE VETERAN HAS ANKYLOSIS OF ANY THUMB OR FINGER JOINTS. INDICATE SEVERITY OF ANKYLOSIS AND SIDE AFFECTED (CHECK ALL THAT APPLY):</p> <p>INDEX FINGER</p> <p>MCP joint</p> <p><input checked="" type="checkbox"/> No ankylosis</p> <p><input type="checkbox"/> MCP ankylosis</p> <p>If ankylosed, is there rotation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, is there angulation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, what is the position of ankylosis?</p> <p><input type="checkbox"/> In extension <input type="checkbox"/> In full flexion</p> <p><input type="checkbox"/> Other, _____ degrees of flexion</p> <p>PIP joint</p> <p><input checked="" type="checkbox"/> No ankylosis</p> <p><input type="checkbox"/> PIP ankylosis</p> <p>If ankylosed, is there rotation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, is there angulation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, what is the position of ankylosis?</p> <p><input type="checkbox"/> In extension <input type="checkbox"/> In full flexion</p> <p><input type="checkbox"/> Other, _____ degrees of flexion</p>
<p>LONG FINGER</p> <p>MCP joint</p> <p><input checked="" type="checkbox"/> No ankylosis</p> <p><input type="checkbox"/> MCP ankylosis</p> <p>If ankylosed, is there rotation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, is there angulation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, what is the position of ankylosis?</p> <p><input type="checkbox"/> In extension <input type="checkbox"/> In full flexion</p> <p><input type="checkbox"/> Other, _____ degrees of flexion</p> <p>PIP joint</p> <p><input checked="" type="checkbox"/> No ankylosis</p> <p><input type="checkbox"/> PIP ankylosis</p> <p>If ankylosed, is there rotation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, is there angulation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, what is the position of ankylosis?</p> <p><input type="checkbox"/> In extension <input type="checkbox"/> In full flexion</p> <p><input type="checkbox"/> Other, _____ degrees of flexion</p>	<p>LONG FINGER</p> <p>MCP joint</p> <p><input checked="" type="checkbox"/> No ankylosis</p> <p><input type="checkbox"/> MCP ankylosis</p> <p>If ankylosed, is there rotation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, is there angulation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, what is the position of ankylosis?</p> <p><input type="checkbox"/> In extension <input type="checkbox"/> In full flexion</p> <p><input type="checkbox"/> Other, _____ degrees of flexion</p> <p>PIP joint</p> <p><input checked="" type="checkbox"/> No ankylosis</p> <p><input type="checkbox"/> PIP ankylosis</p> <p>If ankylosed, is there rotation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, is there angulation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, what is the position of ankylosis?</p> <p><input type="checkbox"/> In extension <input type="checkbox"/> In full flexion</p> <p><input type="checkbox"/> Other, _____ degrees of flexion</p>
<p>RING FINGER</p> <p>MCP joint</p> <p><input checked="" type="checkbox"/> No ankylosis</p> <p><input type="checkbox"/> MCP ankylosis</p> <p>If ankylosed, is there rotation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, is there angulation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>RING FINGER</p> <p>MCP joint</p> <p><input checked="" type="checkbox"/> No ankylosis</p> <p><input type="checkbox"/> MCP ankylosis</p> <p>If ankylosed, is there rotation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If ankylosed, is there angulation of a bone? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

RING FINGER (*continued*)

If ankylosed, what is the position of ankylosis?

- ☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

PIP joint

- ☒ No ankylosis
☐ PIP ankylosis

If ankylosed, is there rotation of a bone? ☐ YES ☐ NO

If ankylosed, is there angulation of a bone? ☐ YES ☐ NO

If ankylosed, what is the position of ankylosis?

- ☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

RING FINGER (*continued*)

If ankylosed, what is the position of ankylosis?

- ☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

PIP joint

- ☒ No ankylosis
☐ PIP ankylosis

If ankylosed, is there rotation of a bone? ☐ YES ☐ NO

If ankylosed, is there angulation of a bone? ☐ YES ☐ NO

If ankylosed, what is the position of ankylosis?

- ☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

LITTLE FINGER

MCP joint

- ☒ No ankylosis
☐ MCP ankylosis

If ankylosed, is there rotation of a bone? ☐ YES ☐ NO

If ankylosed, is there angulation of a bone? ☐ YES ☐ NO

If ankylosed, what is the position of ankylosis?

- ☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

PIP joint

- ☒ No ankylosis
☐ PIP ankylosis

If ankylosed, is there rotation of a bone? ☐ YES ☐ NO

If ankylosed, is there angulation of a bone? ☐ YES ☐ NO

If ankylosed, what is the position of ankylosis?

- ☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

LITTLE FINGER

MCP joint

- ☒ No ankylosis
☐ MCP ankylosis

If ankylosed, is there rotation of a bone? ☐ YES ☐ NO

If ankylosed, is there angulation of a bone? ☐ YES ☐ NO

If ankylosed, what is the position of ankylosis?

- ☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

PIP joint

- ☒ No ankylosis
☐ PIP ankylosis

If ankylosed, is there rotation of a bone? ☐ YES ☐ NO

If ankylosed, is there angulation of a bone? ☐ YES ☐ NO

If ankylosed, what is the position of ankylosis?

- ☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

THUMB

CMC joint

- ☒ No ankylosis
☐ CMC ankylosis

If ankylosed, is there rotation of a bone? ☐ YES ☐ NO

If ankylosed, is there angulation of a bone? ☐ YES ☐ NO

If ankylosed, what is the position of ankylosis?

- ☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

MCP joint

- ☒ No ankylosis
☐ MCP ankylosis

If ankylosed, is there rotation of a bone? ☐ YES ☐ NO

If ankylosed, is there angulation of a bone? ☐ YES ☐ NO

If ankylosed, what is the position of ankylosis?

- ☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

THUMB

CMC joint

- ☒ No ankylosis
☐ CMC ankylosis

If ankylosed, is there rotation of a bone? ☐ YES ☐ NO

If ankylosed, is there angulation of a bone? ☐ YES ☐ NO

If ankylosed, what is the position of ankylosis?

- ☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

MCP joint

- ☒ No ankylosis
☐ MCP ankylosis

If ankylosed, is there rotation of a bone? ☐ YES ☐ NO

If ankylosed, is there angulation of a bone? ☐ YES ☐ NO

If ankylosed, what is the position of ankylosis?

- ☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

THUMB (continued)

IP joint

- ☒ No ankylosis
☐ IP ankylosis

If ankylosed, is there rotation of a bone? ☐ YES ☐ NO
If ankylosed, is there angulation of a bone? ☐ YES ☐ NO
If ankylosed, what is the position of ankylosis?
☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

5B. DOES THE ANKYLOSIS RESULT IN LIMITATION OF MOTION OF OTHER DIGITS OR INTERFERENCE WITH OVERALL FUNCTION OF THE HAND?

☐ YES ☐ NO

If "YES," please describe and provide rationale for your response.

THUMB (continued)

IP joint

- ☒ No ankylosis
☐ IP ankylosis

If ankylosed, is there rotation of a bone? ☐ YES ☐ NO
If ankylosed, is there angulation of a bone? ☐ YES ☐ NO
If ankylosed, what is the position of ankylosis?
☐ In extension ☐ In full flexion
☐ Other, _____ degrees of flexion

5B. DOES THE ANKYLOSIS RESULT IN LIMITATION OF MOTION OF OTHER DIGITS OR INTERFERENCE WITH OVERALL FUNCTION OF THE HAND?

☐ YES ☐ NO

If "YES," please describe and provide rationale for your response.

SECTION VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS AND SCARS

6A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☒ NO

If "YES," describe (brief summary):

6B. DOES THE VETERAN HAVE ANY SCARS OR OTHER DISFIGUREMENT (OF THE SKIN) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☒ NO

If "YES," also complete the appropriate dermatological questionnaire.

SECTION VII - ASSISTIVE DEVICES

7A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES?

☐ YES ☒ NO

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

☐ Brace

Frequency of use: ☐ Occasional ☐ Regular ☐ Constant

☐ Other, describe:

Frequency of use: ☐ Occasional ☐ Regular ☐ Constant

7B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION, INDICATE THE SIDE, AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION.

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

SECTION VIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

NOTE: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prosthesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

8A. DUE TO THE VETERAN'S HAND, FINGER, OR THUMB CONDITION(S), IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTIONS REMAIN 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 extremities for which this applies: ☐ Right upper ☐ Left upper

8B. FOR EACH CHECKED EXTREMITY, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, DESCRIBE LOSS OF EFFECTIVE FUNCTION AND PROVIDE SPECIFIC EXAMPLES (brief summary):

SECTION IX - DIAGNOSTIC TESTING

NOTE: Testing listed below is not indicated for every condition. The diagnosis of degenerative arthritis (osteoarthritis) or post-traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, even if in the past, no further imaging studies are required by VA, even if arthritis has worsened.

9A. HAVE CLINICALLY RELEVANT DIAGNOSTIC IMAGING STUDIES OR OTHER DIAGNOSTIC PROCEDURES BEEN PERFORMED OR REVIEWED IN CONJUNCTION WITH THIS EXAMINATION?

- ☐ YES ☒ NO

9B. IF "YES," IS DEGENERATIVE OR POST-TRAUMATIC ARTHRITIS DOCUMENTED?

- ☐ YES ☐ NO

Indicate side: ☐ RIGHT ☐ LEFT ☐ BOTH

9C. IS DEGENERATIVE OR POST-TRAUMATIC ARTHRITIS DOCUMENTED IN MULTIPLE JOINTS OF THE SAME HAND, INCLUDING THUMB AND FINGERS?

- ☐ YES ☐ NO

If "YES," indicate side: ☐ RIGHT ☐ LEFT ☐ BOTH

9D. IF "YES," (TO 9B AND/OR 9C), PROVIDE TYPE OF TEST OR PROCEDURE, DATE, AND RESULTS (BRIEF SUMMARY):

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

9E. ARE THERE ANY OTHER CLINICALLY RELEVANT DIAGNOSTIC TEST FINDINGS OR RESULTS RELATED TO THE CLAIMED CONDITION(S) AND/OR DIAGNOSIS(ES), THAT WERE REVIEWED IN CONJUNCTION WITH THIS EXAMINATION?

☒ YES ☐ NO

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

Type of Test or Procedure:

Bilateral hand x-ray

Date of Test:

08/2024

Results (brief summary):

degenerative changes along the interphalangeal and MCP joints

9F. IF ANY TEST RESULTS ARE OTHER THAN NORMAL, INDICATE RELATIONSHIP OF ABNORMAL FINDINGS TO DIAGNOSED CONDITIONS:

Directly related to bilateral hand osteoarthritis

SECTION X - FUNCTIONAL IMPACT

NOTE: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

10A. REGARDLESS OF THE VETERAN'S CURRENT EMPLOYMENT STATUS, DO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION IMPACT HIS/HER ABILITY TO PERFORM ANY TYPE OF OCCUPATIONAL TASK (SUCH AS STANDING, WALKING, LIFTING, SITTING, ETC.)?

☒ YES ☐ NO

If "YES," describe the functional impact of each condition, providing one or more examples:

Current OR if retired/unemployed, previous occupation:

Current: Military

0-1 week work time lost in last 12 months

Service member reports bilateral hand pain, including pain in all the fingers results in difficulty gripping objects.

SECTION XI - REMARKS

11A. REMARKS (IF ANY - PLEASE IDENTIFY THE SECTION TO WHICH THE REMARK PERTAINS WHEN APPROPRIATE).

Is there a need for the Veteran/Service Member to follow up with his or her primary care provider regarding any life threatening or abnormal findings in this examination (not limited to claimed condition(s))? No

Reason x-rays not needed or not performed:
X-rays on the day of exam were not clinically indicated

[REDACTED]

REMARKS (*cont.*):

Section III: ROM: A goniometer was used to measure ROM.

REMARKS (cont.):

[REDACTED]

HAND AND FINGERS DISABILITY BENEFITS QUESTIONNAIRE

REMARKS (cont.):

Is the Veteran homeless? No

Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION XII - EXAMINER’S CERTIFICATION AND SIGNATURE

CERTIFICATION: To the best of my knowledge, the information contained herein is accurate, complete and current.

12A. EXAMINER'S SIGNATURE <div>Digitally Signed 02/28/2025 01:03:43 PM</div>		12B. EXAMINER'S PRINTED NAME <div>PA-C Physician Assistant – General Practice</div>	12C. DATE SIGNED 2/28/2025
12D. EXAMINER'S PHONE/FAX NUMBERS <div></div>	12E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER <div></div>		12F. MEDICAL LICENSE NUMBER AND STATE PA15701, TX
12G. EXAMINER'S ADDRESS 540 Oak Centre Drive Suite 101 San Antonio TX 78258			