Department of Veterans Affairs

HERNIAS (INCLUDING ABDOMINAL, INGUINAL AND FEMORAL HERNIAS) DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY OR REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM.

Note - 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. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the veteran's application. VA reserves the right to confirm the authenticity of ALL questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

☐ Veteran/Claimant

☐ Other: please describe

Are you a VA Healthcare provider? ◯ Yes ◯ No

Is the Veteran regularly seen as a patient in your clinic? ◯ Yes ◯ No

Was the Veteran examined in person? ◯ Yes ◯ No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

◯ No records were reviewed

◯ Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER HAD ANY HERNIA CONDITIONS? *(This is the condition the Veteran is claiming or for which an exam has been requested)*

☐ YES ☐ NO

1B. IF YES, SELECT THE VETERAN'S CONDITION *(Check all that apply):*

☐ INGUINAL HERNIA *(If checked, complete Section III.1)* ICD code: __________ Date of diagnosis: __________

☐ FEMORAL HERNIA *(If checked, complete Section III.2)* ICD code: __________ Date of diagnosis: __________

☐ VENTRAL HERNIA *(If checked, complete Section III.3)* ICD code: __________ Date of diagnosis: __________

☐ OTHER *(Specify):*

OTHER DIAGNOSIS #1:

__________ ICD code: __________ Date of diagnosis: __________

OTHER DIAGNOSIS #2:

__________ ICD code: __________ Date of diagnosis: __________

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO INGUINAL, FEMORAL OR VENTRAL HERNIAS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S HERNIA CONDITIONS *(brief summary):*

SECTION III - HERNIA CONDITIONS

1. INGUINAL HERNIA

A. SURGICAL STATUS *(check all that apply):*

☐ Surgery performed *(Indicate side):*

- ☐ Right: Date and type of surgery: __________ __________
- ☐ Left: Date and type of surgery: __________ __________

☐ No previous surgery but hernia appears operable and remediable *(Indicate side):* ☐ Right: ☐ Left:

☐ Irremediable, provide reason: __________ *(Indicate side):* ☐ Right: ☐ Left:

☐ Inoperable, provide reason: __________ *(Indicate side):* ☐ Right: ☐ Left:

☐ Recurrent hernia following surgical repair *(Indicate status of postoperative recurrent hernia):*

- ☐ Recurrent hernia appears operable and remediable *(If checked, indicate side):* ☐ Right: ☐ Left:
- ☐ Irremediable, provide reason: __________ *(Indicate side):* ☐ Right: ☐ Left:
- ☐ Inoperable, provide reason: __________ *(Indicate side):* ☐ Right: ☐ Left:

B. EXAM

Right: ☐ No hernia detected ☐ No true hernia protrusion ☐ Small hernia ☐ Large hernia

Left: ☐ No hernia detected ☐ No true hernia protrusion ☐ Small hernia ☐ Large hernia

C. ABILITY TO BE REDUCED *(If inguinal hernia present, indicate ability to be reduced):*

Right: ☐ Readily reducible ☐ Not readily reducible

Left: ☐ Readily reducible ☐ Not readily reducible

D. INDICATION FOR SUPPORT *(Is there an indication for a supporting belt?)*

☐ YES ☐ NO *(If "Yes," can the hernia be supported by truss or belt?):*

- ☐ Yes, can be well supported by truss or belt *(Indicate side well supported):* ☐ Right: ☐ Left:
- ☐ Not well supported by truss or belt *(Indicate side not well supported):* ☐ Right: ☐ Left:
- ☐ N/A, no truss or belt tried or used

SECTION III - HERNIA CONDITIONS *(Continued)*

2. FEMORAL HERNIA

A. SURGICAL STATUS *(check all that apply):*

☐ Surgery performed *(Indicate side):*
- ☐ Right: Date and type of surgery: __________ ____________________
- ☐ Left: Date and type of surgery: __________ ____________________

☐ No previous surgery but hernia appears operable and remediable *(Indicate side):* ☐ Right: ☐ Left:

☐ Irremediable, provide reason: ____________________ *(Indicate side):* ☐ Right: ☐ Left:

☐ Inoperable, provide reason: ____________________ *(Indicate side):* ☐ Right: ☐ Left:

☐ Recurrent hernia following surgical repair *(If checked, indicate status of postoperative recurrent hernia):*
- ☐ Recurrent hernia appears operable and remediable *(Indicate side):* ☐ Right: ☐ Left:
- ☐ Irremediable, provide reason: ____________________ *(Indicate side):* ☐ Right: ☐ Left:
- ☐ Inoperable, provide reason: ____________________ *(Indicate side):* ☐ Right: ☐ Left:

B. EXAM

Right: ☐ No hernia detected ☐ No true hernia protrusion ☐ Small hernia ☐ Large hernia

Left: ☐ No hernia detected ☐ No true hernia protrusion ☐ Small hernia ☐ Large hernia

C. ABILITY TO BE REDUCED

Right: ☐ Readily reducible ☐ Not readily reducible

Left: ☐ Readily reducible ☐ Not readily reducible

D. INDICATION FOR SUPPORT *(Is there an indication for a supporting belt?)*

☐ YES ☐ NO *(If "Yes," can the hernia be supported by truss or belt?):*
- ☐ Yes, can be well supported by truss or belt *(Indicate side well supported):* ☐ Right: ☐ Left:
- ☐ Not well supported by truss or belt *(Indicate side not well supported):* ☐ Right: ☐ Left:
- ☐ N/A, no truss or belt tried or used

3. VENTRAL HERNIA

A. SURGICAL STATUS *(check all that apply):*

☐ Surgery performed

Date and type of surgery: __________ ____________________

☐ No previous surgery but hernia appears operable and remediable

☐ Irremediable, provide reason: ____________________

☐ Inoperable, provide reason: ____________________

☐ Recurrent hernia following surgical repair *(Indicate status of postoperative recurrent hernia):*
- ☐ Recurrent hernia appears operable and remediable
- ☐ Irremediable, provide reason: ____________________
- ☐ Inoperable, provide reason: ____________________

B. EXAM *(check all that apply):*

- ☐ No hernia detected
- ☐ Healed postoperative ventral hernia repair
- ☐ Healed postoperative wounds with weakening of abdominal wall
- ☐ Small ventral hernia
- ☐ Large ventral hernia
- ☐ Massive, persistent, severe diastasis of recti muscles
- ☐ Extensive diffuse destruction or weakening of muscular and fascial support of abdominal wall so as to be inoperable
- ☐ Other, describe: ____________________

C. INDICATION FOR SUPPORT *(Is there an indication for a supporting belt?)*

☐ YES ☐ NO *(If "Yes," can the hernia be supported by truss or belt?):*
- ☐ Yes, can be well supported by truss or belt
- ☐ Not well supported by truss or belt
- ☐ N/A, no truss or belt tried or used

SECTION IV - OTHER PERTINENT PHYSICAL FINDINGS, DIAGNOSTIC TESTING, FUNCTIONAL IMPACT AND REMARKS

1. OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS AND SCARS

1A. 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*):

1B. 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 THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM *(6 square inches)*; OR ARE LOCATED ON THE HEAD, FACE OR NECK? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

☐ YES ☐ NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION: ______________________________ MEASUREMENTS: length __________ cm X width __________ cm.

NOTE: If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

1C. COMMENTS, IF ANY:

2. DIAGNOSTIC TESTING

NOTE - If testing has been performed and reflects the Veteran's current condition, repeat testing is not required. Specific diagnostic testing is not required for hernia examination.

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):*

3. FUNCTIONAL IMPACT

DOES THE VETERAN'S HERNIA CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the Veteran's hernia condition(s), providing one or more examples):*

4. REMARKS

REMARKS *(If any):*

SECTION V - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

5A. PHYSICIAN'S SIGNATURE	5B. PHYSICIAN'S PRINTED NAME	5C. DATE SIGNED

5D. PHYSICIAN'S PHONE AND FAX NUMBERS	5E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	5F. PHYSICIAN'S ADDRESS