



**DEPARTMENT OF VETERANS AFFAIRS
Veterans Benefits Administration
Regional Office**

[REDACTED]

VA File Number

[REDACTED]

Represented By:

[REDACTED]

Rating Decision

06/08/2023

INTRODUCTION

The records reflect that you are a Veteran of the Gulf War Era. You served in the Army from June 19, 1998 to August 3, 2009 and from August 4, 2009 to February 28, 2022. You filed an original disability claim that was received on December 30, 2022. Based on a review of the evidence listed below, we have made the following decision(s) on your claim.

DECISION

1. Service connection for degenerative arthritis, thoracolumbar spine is granted with an evaluation of 40 percent effective March 1, 2022.
2. Service connection for radiculopathy, left leg is granted with an evaluation of 40 percent effective March 1, 2022.
3. Service connection for osteoarthritis, left hip limitation of flexion is granted with an evaluation of 30 percent effective March 1, 2022.
4. Service connection for osteoarthritis, right hip, limitation of flexion is granted with an

evaluation of 30 percent effective March 1, 2022.

5. Service connection for right arm ulnar neuropathy is granted with an evaluation of 30 percent effective March 1, 2022.

6. Service connection for acromioclavicular joint osteoarthritis, left shoulder is granted with an evaluation of 20 percent effective March 1, 2022.

7. Service connection for anterior cruciate ligament tear with osteoarthritis, right knee limitation of extension is granted with an evaluation of 20 percent effective March 1, 2022.

8. Service connection for anterior cruciate ligament tear with osteoarthritis, right knee limitation of flexion is granted with an evaluation of 20 percent effective March 1, 2022.

9. Service connection for cervical strain is granted with an evaluation of 20 percent effective March 1, 2022.

10. Service connection for osteoarthritis, left hip thigh impairment (claimed as thigh strain) is granted with an evaluation of 20 percent effective March 1, 2022.

11. Service connection for osteoarthritis, left knee limitation of extension. is granted with an evaluation of 20 percent effective March 1, 2022.

12. Service connection for osteoarthritis, left knee limitation of flexion is granted with an evaluation of 20 percent effective March 1, 2022.

13. Service connection for osteoarthritis, right hip, thigh impairment is granted with an evaluation of 20 percent effective March 1, 2022.

14. Service connection for right elbow, epicondyitis/tendonitis, limitation of flexion and extension is granted with an evaluation of 20 percent effective March 1, 2022.

15. Service connection for right elbow, epicondyitis/tendonitis, limitation of supination/pronation is granted with an evaluation of 20 percent effective March 1, 2022.

16. Service connection for s/p rotator cuff tear with acromioclavicular joint osteoarthritis , right shoulder is granted with an evaluation of 20 percent effective March 1, 2022.

17. Service connection for anterior cruciate ligament tear with osteoarthritis, right knee instability is granted with an evaluation of 10 percent effective March 1, 2022.

18. Service connection for osteoarthritis, left hip limitation of extension is granted with an evaluation of 10 percent effective March 1, 2022.

19. Service connection for plantar fasciitis, with bone spurs bilateral is granted with an evaluation of 10 percent effective March 1, 2022.
20. Service connection for tinnitus is granted with an evaluation of 10 percent effective March 1, 2022.
21. Service connection for osteoarthritis, right hip, limitation of extension is granted with an evaluation of 10 percent effective January 1, 2023.
22. Basic eligibility to Dependents' Educational Assistance based on permanent and total disability status is established from March 1, 2022.
23. Service connection for radiculopathy, right leg sciatic is denied.
24. Service connection for right 5th toe sprain is denied.
25. Service connection for sinusitis is denied.

EVIDENCE

- VA Form 21-4138 Statement In Support of Claim, received December 30, 2022
- VA 21-526EZ, Fully Developed Claim (Compensation), received on February 13, 2023
- CAVC Decision x 200 received on February 13, 2023
- C&P Exam, received on January 23, 2023
- VA 21-526EZ, Fully Developed Claim (Compensation), received on December 30, 2022
- CAPRI, VA Medical Center, [REDACTED] for the period January 18, 2023 to February 7, 2023
- Photographs, received on February 13, 2023
- VA Form 21-10210 - Lay Witness Statement, received February 13, 2023
- VA Form 21-10210 - Lay Witness Statement, received February 13, 2023
- Private Disability Questionnaires Dr [REDACTED] on February 13, 2023
- VA 27-0820 Report of General Information, received on March 03, 2023
- Service treatment and Personnel records for the period of service from June 19, 1998 to February 28, 2022

REASONS FOR DECISION

1. Service connection for degenerative arthritis, thoracolumbar spine.

Service connection for degenerative arthritis, thoracolumbar spine has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from

the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 40 percent is assigned from March 1, 2022.

We have assigned a 40 percent evaluation for your degenerative arthritis, thoracolumbar spine based on:

- Forward flexion of the thoracolumbar spine 30 degrees or less

Additional symptom(s) include:

- Combined range of motion of the thoracolumbar spine not greater than 120 degrees
- Painful motion

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and are not warranted.

A higher evaluation of 50 percent is not warranted for diseases and injuries of the thoracolumbar spine unless the evidence shows:

- Unfavorable ankylosis of the entire thoracolumbar spine. (38 CFR 4.71a)

2. Service connection for radiculopathy, left leg.

Service connection for radiculopathy, left leg has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 40 percent is assigned from March 1, 2022.

We have assigned a 40 percent evaluation for your radiculopathy, left leg based on:

- Moderately severe incomplete paralysis (38 CFR 4.124a)

A higher evaluation of 60 percent is not warranted for paralysis of the sciatic nerve unless the evidence shows nerve damage is severe with marked muscular atrophy. (38 CFR 4.120, 38 CFR 4.124a)

3. Service connection for osteoarthritis, left hip limitation of flexion.

Service connection for osteoarthritis, left hip limitation of flexion has been established as directly

related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 30 percent is assigned from March 1, 2022.

We have assigned a 30 percent evaluation for your osteoarthritis, left hip based on:

- Flexion of the thigh limited to 11- 20 degrees

Additional symptom(s) include:

- Painful Abduction
- Painful Adduction
- Painful Extension
- Painful External Rotation
- Painful Flexion
- Painful Internal Rotation

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and are not warranted.

A higher evaluation of 40 percent is not warranted for limitation of flexion of the thigh unless the evidence shows:

- Flexion of the thigh limited to 10 degrees or less. (38 CFR 4.71a)

4. Service connection for osteoarthritis, right hip, limitation of flexion.

Service connection for osteoarthritis, right hip, limitation of flexion has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 30 percent is assigned from March 1, 2022.

We have assigned a 30 percent evaluation for your osteoarthritis, right hip based on:

- Flexion of the thigh limited to 11- 20 degrees

Additional symptom(s) include:

- Painful Abduction
- Painful Adduction
- Painful Extension
- Painful External Rotation
- Painful Flexion
- Painful Internal Rotation

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in *DeLuca v. Brown and Mitchell v. Shinseki*, have been considered and were applied based on additional joint limitation.

A higher evaluation of 40 percent is not warranted for limitation of flexion of the thigh unless the evidence shows:

- Flexion of the thigh limited to 10 degrees or less. (38 CFR 4.71a)

5. Service connection for right arm ulnar neuropathy.

Service connection for right arm ulnar neuropathy has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 30 percent is assigned from March 1, 2022.

We have assigned a 30 percent evaluation for your right arm ulnar neuropathy based on:

- Moderate incomplete paralysis of the major extremity (38 CFR 4.124a)

A higher evaluation of 40 percent is not warranted for paralysis of the ulnar nerve unless the evidence shows nerve damage is severe. (38 CFR 4.120, 38 CFR 4.124a)

6. Service connection for acromioclavicular joint osteoarthritis, left shoulder.

Service connection for acromioclavicular joint osteoarthritis, left shoulder has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 20 percent is assigned from March 1, 2022.

We have assigned a 20 percent evaluation for your acromioclavicular joint osteoarthritis, left shoulder based on:

- Limited motion of the arm at shoulder level (flexion and/or abduction limited to 90 degrees)
- Painful motion of the shoulder

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and were applied based on additional joint limitation.

A higher evaluation of 30 percent is not warranted for limitation of motion of the arm unless the evidence shows:

- Limited motion of the arm, with flexion and/or abduction limited to 25 degrees from the side. (38 CFR 4.69, 38 CFR 4.71a)

7. Service connection for anterior cruciate ligament tear with osteoarthritis, right knee limitation of extension.

Service connection for anterior cruciate ligament tear with osteoarthritis, right knee limitation of extension has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 20 percent is assigned from March 1, 2022.

We have assigned a 20 percent evaluation for your anterior cruciate ligament tear with osteoarthritis, right knee based on:

- Limitation of extension of 15 to 19 degrees

Additional symptom(s) include:

- A diagnosed condition involving the patellofemoral complex with recurrent instability (with or without history of surgical repair) that does not require a prescription from a medical provider for a brace, cane, or walker
- Painful motion of the knee
- Sprain, incomplete ligament tear, or complete ligament tear (repaired, unrepaired, or failed repair) causing persistent instability, without a prescription from a medical provider for an assistive device (e.g., cane(s), crutch(es), walker) or bracing for ambulation

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and are not warranted.

A higher evaluation of 30 percent is not warranted for limitation of extension of the knee unless the evidence shows:

- Limitation of extension of 20 to 29 degrees. (38 CFR 4.71a)

8. Service connection for anterior cruciate ligament tear with osteoarthritis, right knee limitation of flexion.

Service connection for anterior cruciate ligament tear with osteoarthritis, right knee limitation of flexion has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 20 percent is assigned from March 1, 2022.

We have assigned a 20 percent evaluation for your anterior cruciate ligament tear with osteoarthritis, right knee based on:

- Limitation of flexion of 16 to 30 degrees

Additional symptom(s) include:

- A diagnosed condition involving the patellofemoral complex with recurrent instability (with or without history of surgical repair) that does not require a prescription from a medical provider for a brace, cane, or walker
- Painful motion of the knee
- Sprain, incomplete ligament tear, or complete ligament tear (repaired, unrepaired, or failed repair) causing persistent instability, without a prescription from a medical provider for an assistive device (e.g., cane(s), crutch(es), walker) or bracing for ambulation

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and are not warranted.

A higher evaluation of 30 percent is not warranted for limitation of flexion of the knee unless the evidence shows:

- Limitation of flexion of 15 degrees or less. (38 CFR 4.71a)

9. Service connection for cervical strain.

Service connection for cervical strain has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from

the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 20 percent is assigned from March 1, 2022.

We have assigned a 20 percent evaluation for your cervical strain based on:

- Combined range of motion of the cervical spine not greater than 170 degrees
- Forward flexion of the cervical spine greater than 15 degrees but not greater than 30 degrees
- Guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis
- Muscle spasm severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis

Additional symptom(s) include:

- Painful motion

A higher evaluation of 30 percent is not warranted for diseases and injuries of the cervical spine unless the evidence shows:

- Favorable ankylosis of the entire cervical spine; or,
- Forward flexion of the cervical spine 15 degrees or less. (38 CFR 4.71a)

10. Service connection for osteoarthritis, left hip thigh impairment (claimed as thigh strain).

Service connection for osteoarthritis, left hip thigh impairment (claimed as thigh strain) has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 20 percent is assigned from March 1, 2022.

We have assigned a 20 percent evaluation for your osteoarthritis, left hip based on:

- Limitation of abduction of the thigh, motion lost beyond 10 degrees

Additional symptom(s) include:

- Limitation of internal rotation of the thigh
- Limitation of rotation of the thigh, can toe-out more than 15 degrees on the affected leg
- Painful Abduction
- Painful Adduction
- Painful Extension
- Painful External Rotation

- Painful Flexion
- Painful Internal Rotation

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and are not warranted.

This is the highest schedular evaluation allowed under the law for impairment of the thigh. (38 CFR 4.71a)

Additionally, a higher evaluation of 60 percent is not warranted for ankylosis of the hip unless the evidence shows:

- Favorable ankylosis in flexion at an angle between 20 and 40 degrees and slight adduction or abduction. (38 CFR 4.71a)

11. Service connection for osteoarthritis, left knee limitation of extension..

Service connection for osteoarthritis, left knee limitation of extension. has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 20 percent is assigned from March 1, 2022.

We have assigned a 20 percent evaluation for your osteoarthritis, left knee based on:

- Limitation of extension of 15 to 19 degrees

Additional symptom(s) include:

- Painful motion of the knee

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and are not warranted.

A higher evaluation of 30 percent is not warranted for limitation of extension of the knee unless the evidence shows:

- Limitation of extension of 20 to 29 degrees. (38 CFR 4.71a)

12. Service connection for osteoarthritis, left knee limitation of flexion.

Service connection for osteoarthritis, left knee limitation of flexion has been established as

directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 20 percent is assigned from March 1, 2022.

We have assigned a 20 percent evaluation for your osteoarthritis, left knee based on:

- Limitation of flexion of 16 to 30 degrees

Additional symptom(s) include:

- Painful motion of the knee

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and are not warranted.

A higher evaluation of 30 percent is not warranted for limitation of flexion of the knee unless the evidence shows:

- Limitation of flexion of 15 degrees or less. (38 CFR 4.71a)

13. Service connection for osteoarthritis, right hip, thigh impairment.

Service connection for osteoarthritis, right hip, thigh impairment has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 20 percent is assigned from March 1, 2022.

We have assigned a 20 percent evaluation for your osteoarthritis, right hip based on:

- Limitation of abduction of the thigh, motion lost beyond 10 degrees

Additional symptom(s) include:

- Limitation of internal rotation of the thigh
- Limitation of rotation of the thigh, can toe-out more than 15 degrees on the affected leg
- Painful Abduction
- Painful Adduction
- Painful Extension

- Painful External Rotation
- Painful Flexion
- Painful Internal Rotation

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and were applied based on additional joint limitation.

This is the highest schedular evaluation allowed under the law for impairment of the thigh. (38 CFR 4.71a)

Additionally, a higher evaluation of 60 percent is not warranted for ankylosis of the hip unless the evidence shows:

- Favorable ankylosis in flexion at an angle between 20 and 40 degrees and slight adduction or abduction. (38 CFR 4.71a)

14. Service connection for right elbow, epicondylitis/tendonitis, limitation of flexion and extension.

Service connection for right elbow, epicondylitis/tendonitis, limitation of flexion and extension has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 20 percent is assigned from March 1, 2022.

We have assigned a 20 percent evaluation for your right elbow, epicondylitis/tendonitis based on:

- Flexion is limited to 100 degrees or less and extension is limited to 45 degrees or more

Additional symptom(s) include:

- Limitation of pronation: motion lost beyond last quarter of arc, the hand does not approach full pronation
- Limitation of supination greater than 30 degrees
- Painful motion of the elbow
- Painful motion of the forearm

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and are not warranted.

This is the highest schedular evaluation allowed under the law for forearm, flexion limited to 100 degrees and extension to 45 degrees. (38 CFR 4.69, 38 CFR 4.71a)

Additionally, a higher evaluation of 30 percent is not warranted for limitation of flexion of the forearm unless the evidence shows:

- Flexion is limited to 56-70 degrees. (38 CFR 4.69, 38 CFR 4.71a)

Additionally, a higher evaluation of 30 percent is not warranted for limitation of extension of the forearm unless the evidence shows:

- Extension limited to 90-99 degrees. (38 CFR 4.69, 38 CFR 4.71a)

15. Service connection for right elbow, epicondyitis/tendonitis, limitation of supination/pronation.

Service connection for right elbow, epicondyitis/tendonitis, limitation of supination/pronation has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 20 percent is assigned from March 1, 2022.

We have assigned a 20 percent evaluation for your tight elbow, epicondyitis/tendonitis based on:

- Limitation of pronation: motion lost beyond last quarter of arc, the hand does not approach full pronation

Additional symptom(s) include:

- Extension limited to less than 45 degrees
- Limitation of supination greater than 30 degrees
- Painful motion of the elbow
- Painful motion of the forearm

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and are not warranted.

A higher evaluation of 30 percent is not warranted for impairment of supination and pronation unless the evidence shows:

- Motion lost beyond middle of arc; or,
- The hand fixed in full pronation. (38 CFR 4.69, 38 CFR 4.71a)

16. Service connection for s/p rotator cuff tear with acromioclavicular joint osteoarthritis , right shoulder.

Service connection for s/p rotator cuff tear with acromioclavicular joint osteoarthritis , right shoulder has been established as directly related to military service. (38 CFR 3.303, 38 CFR

3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 20 percent is assigned from March 1, 2022.

We have assigned a 20 percent evaluation for your s/p rotator cuff tear with acromioclavicular joint osteoarthritis , right shoulder based on:

- Limited motion of the arm at shoulder level (flexion and/or abduction limited to 90 degrees)
- Painful motion of the shoulder

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and are not warranted.

A higher evaluation of 30 percent is not warranted for limitation of motion of the arm unless the evidence shows:

- Limited motion of the arm midway between side and shoulder level (flexion and/or abduction limited to 45 degrees). (38 CFR 4.69, 38 CFR 4.71a)

17. Service connection for anterior cruciate ligament tear with osteoarthritis, right knee instability.

Service connection for anterior cruciate ligament tear with osteoarthritis, right knee instability has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 10 percent is assigned from March 1, 2022.

We have assigned a 10 percent evaluation for your anterior cruciate ligament tear with osteoarthritis, right knee based on:

- A diagnosed condition involving the patellofemoral complex with recurrent instability (with or without history of surgical repair) that does not require a prescription from a medical provider for a brace, cane, or walker
- Sprain, incomplete ligament tear, or complete ligament tear (repaired, unrepaired, or failed repair) causing persistent instability, without a prescription from a medical provider for an assistive device (e.g., cane(s), crutch(es), walker) or bracing for ambulation

Additional symptom(s) include:

- Painful motion of the knee

A higher evaluation of 20 percent is not warranted for impairment of the knee unless the evidence shows:

- A diagnosed condition involving the patellofemoral complex with recurrent instability after surgical repair that requires a prescription by a medical provider for one of the following: a brace, cane, or walker; or,
- Sprain, incomplete ligament tear, or repaired complete ligament tear causing persistent instability and a medical provider prescribes a brace and/or assistive device (e.g., cane(s), crutch(es), walker) for ambulation; or,
- Unrepaired or failed repair of complete ligament tear causing persistent instability, and a medical provider prescribes either an assistive device (e.g. cane(s), crutch(es), walker) or bracing for ambulation. (38 CFR 4.71a)

18. Service connection for osteoarthritis, left hip limitation of extension.

Service connection for osteoarthritis, left hip limitation of extension has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 10 percent is assigned from March 1, 2022.

We have assigned a 10 percent evaluation for your osteoarthritis, left hip based on:

- Extension of the thigh limited to 5 degrees

Additional symptom(s) include:

- Painful Abduction
- Painful Adduction
- Painful Extension
- Painful External Rotation
- Painful Flexion
- Painful Internal Rotation

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and are not warranted.

This is the highest schedular evaluation allowed under the law for limitation of extension of the thigh. (38 CFR 4.71a)

Additionally, a higher evaluation of 60 percent is not warranted for ankylosis of the hip unless the evidence shows:

- Favorable ankylosis in flexion at an angle between 20 and 40 degrees and slight adduction or abduction. (38 CFR 4.71a)

19. Service connection for plantar fasciitis, with bone spurs bilateral.

Service connection for plantar fasciitis, with bone spurs bilateral has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 10 percent is assigned from March 1, 2022.

We have assigned a 10 percent evaluation for your plantar fasciitis, with bone spurs bilateral based on:

- No relief from non-surgical treatment for the left foot
- No relief from non-surgical treatment for the right foot

A higher evaluation of 20 percent is not warranted for plantar fasciitis unless the evidence shows:

- No relief from both non-surgical and surgical treatment, unilateral. (38 CFR 4.71a)

20. Service connection for tinnitus.

Service connection for tinnitus has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is March 1, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 10 percent is assigned from March 1, 2022.

We have assigned a 10 percent evaluation for your tinnitus based on:

- Recurrent

A single evaluation for recurrent tinnitus is assigned whether the sound is perceived in one ear, both ears, or in the head.

This is the highest schedular evaluation allowed under the law for tinnitus. (38 CFR 4.87)

21. Service connection for osteoarthritis, right hip, limitation of extension.

Service connection for osteoarthritis, right hip, limitation of extension has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

An evaluation of 10 percent is assigned from January 1, 2023.

We have assigned a 10 percent evaluation for your osteoarthritis, right hip based on:

- Extension of the thigh limited to 5 degrees

Additional symptom(s) include:

- Painful Abduction
- Painful Adduction
- Painful Extension
- Painful External Rotation
- Painful Flexion
- Painful Internal Rotation

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and were applied based on additional joint limitation.

This is the highest schedular evaluation allowed under the law for limitation of extension of the thigh. (38 CFR 4.71a)

Additionally, a higher evaluation of 60 percent is not warranted for ankylosis of the hip unless the evidence shows:

- Favorable ankylosis in flexion at an angle between 20 and 40 degrees and slight adduction or abduction. (38 CFR 4.71a)

22. Eligibility to Dependents' Educational Assistance under 38 U.S.C. Chapter 35 based on permanent and total disability status.

Eligibility for Dependents' Educational Assistance is derived from a Veteran who was discharged under other than dishonorable conditions; and has permanent and total service-connected disability(ies); or permanent and total disability(ies) existed at the time of death; or the Veteran died as a result of service-connected disability(ies). Also, eligibility exists for a service member who died in service. Finally, eligibility can be derived from a service member who, as a member of the armed forces on active duty, has been listed for more than 90 days as missing in action; captured in line of duty by a hostile force; or forcibly detained or interned in line of duty by a foreign government or power. (38 USC Chapter 35, 38 CFR 3.807, 38 CFR 21.3021)

Basic eligibility for Dependents' Educational Assistance is granted as the evidence shows you

currently have a totally disabling service-connected disability or disabilities, permanent in nature. (38 USC Chapter 35, 38 CFR 3.807, 38 CFR 21.3021)

Evidence we have used to grant permanent and total disability status:

All examinations submitted with claim
Service treatment records

23. Service connection for radiculopathy, right leg sciatic.

Service connection may be granted for a disability which began in military service or was caused by some event or experience in service. Service connection for radiculopathy, right leg sciatic is denied because the medical evidence of record fails to show that this disability has been clinically diagnosed. (38 CFR 3.303, 38 CFR 3.304)

The evidence does not show an event, disease or injury in service. (38 CFR 3.303, 38 CFR 3.304) Your service treatment records do not contain complaints, treatment, or diagnosis for this condition.

24. Service connection for right 5th toe sprain.

Service connection may be granted for a disability which began in military service or was caused by some event or experience in service. Service connection for right 5th toe sprain is denied because the medical evidence of record fails to show that this disability has been clinically diagnosed. (38 CFR 3.303, 38 CFR 3.304)

The evidence does not show an event, disease or injury in service. (38 CFR 3.303, 38 CFR 3.304) Your service treatment records do not contain complaints, treatment, or diagnosis for this condition.

25. Service connection for sinusitis.

Service connection may be granted for a disability which began in military service or was caused by some event or experience in service. Service connection for sinusitis is denied because the medical evidence of record fails to show that this disability has been clinically diagnosed. (38 CFR 3.303, 38 CFR 3.304)

The evidence does not show an event, disease or injury in service. (38 CFR 3.303, 38 CFR 3.304) Your service treatment records do not contain complaints, treatment, or diagnosis for this condition.

REFERENCES:

June 16, 2023



We made a decision on your VA benefits.

Dear

This letter will guide you through the information you should know and steps you may take now that VA has made a decision about your benefits.

Your Benefit Information:

- Service connection for degenerative arthritis, thoracolumbar spine is granted with an evaluation of 40 percent effective March 1, 2022.
- Service connection for radiculopathy, left leg is granted with an evaluation of 40 percent effective March 1, 2022.
- Service connection for osteoarthritis, left hip limitation of flexion is granted with an evaluation of 30 percent effective March 1, 2022.
- Service connection for osteoarthritis, right hip, limitation of flexion is granted with an evaluation of 30 percent effective March 1, 2022.
- Service connection for right arm ulnar neuropathy is granted with an evaluation of 30 percent effective March 1, 2022.
- Service connection for acromioclavicular joint osteoarthritis, left shoulder is granted with an evaluation of 20 percent effective March 1, 2022.
- Service connection for anterior cruciate ligament tear with osteoarthritis, right knee limitation of extension is granted with an evaluation of 20 percent effective March 1, 2022.
- Service connection for anterior cruciate ligament tear with osteoarthritis, right knee limitation of flexion is granted with an evaluation of 20 percent effective March 1, 2022.
- Service connection for cervical strain is granted with an evaluation of 20 percent effective March 1, 2022.
- Service connection for osteoarthritis, left hip thigh impairment (claimed as thigh strain) is granted with an evaluation of 20 percent effective March 1, 2022.
- Service connection for osteoarthritis, left knee limitation of extension is granted with an evaluation of 20 percent effective March 1, 2022.



We have included with this letter:

1. Explanation of Payment
2. Additional Benefits
3. Where to Send Your Correspondence
4. VA Form 20-0998
5. Rating Decision
6. Fraud Prevention Attachment

Contact information:

Web: www.vets.gov

Phone: 1-800-827-1000

TDD: 711

To send questions online: visit

<https://iris.custhelp.com/>

Social Media:

Twitter: @VAVetBenefits

Facebook: www.facebook.com/VeteransBenefits

Your representative:

You appointed

as your accredited representative. They have also received a copy of this letter.

They can help you with any questions you have about your claim.

If you or someone you know is in crisis, call the *Veterans Crisis Line* at 1-800-273-8255 and press 1.

- Service connection for osteoarthritis, left knee limitation of flexion is granted with an evaluation of 20 percent effective March 1, 2022.
- Service connection for osteoarthritis, right hip, thigh impairment is granted with an evaluation of 20 percent effective March 1, 2022.
- Service connection for right elbow, epicondylitis/tendonitis, limitation of flexion and extension is granted with an evaluation of 20 percent effective March 1, 2022.
- Service connection for right elbow, epicondylitis/tendonitis, limitation of supination/pronation is granted with an evaluation of 20 percent effective March 1, 2022.
- Service connection for s/p rotator cuff tear with acromioclavicular joint osteoarthritis, right shoulder is granted with an evaluation of 20 percent effective March 1, 2022.
- Service connection for anterior cruciate ligament tear with osteoarthritis, right knee instability is granted with an evaluation of 10 percent effective March 1, 2022.
- Service connection for osteoarthritis, left hip limitation of extension is granted with an evaluation of 10 percent effective March 1, 2022.
- Service connection for plantar fasciitis, with bone spurs bilateral is granted with an evaluation of 10 percent effective March 1, 2022.
- Service connection for tinnitus is granted with an evaluation of 10 percent effective March 1, 2022.
- Service connection for osteoarthritis, right hip, limitation of extension is granted with an evaluation of 10 percent effective January 1, 2023.
- Basic eligibility to Dependents' Educational Assistance based on permanent and total disability status is established from March 1, 2022.
- Service connection for radiculopathy, right leg sciatic is denied.
- Service connection for right 5th toe sprain is denied.
- Service connection for sinusitis is denied.

Your combined rating evaluation is:

Combined Rating Evaluation	Effective Date
100%	Mar 1, 2022
100%	Jan 1, 2023

How VA Combines Percentages

If you have more than one condition, VA will combine percentages to determine your overall disability rating. The percentages assigned for each of your conditions may not always add up to your combined rating evaluation. The following website has additional information about how VA combines percentages: <http://www.benefits.va.gov/compensation/rates-index.asp#howcalc>.

See **Rating Decision** to find out why we made this decision.

We granted your claim for additional dependency benefits because the following dependent(s) meet the criteria for establishing a relationship and you have at least a 30%

File Number: [REDACTED]

~~information.~~

~~Your dependents may be eligible for Dependents Educational Assistance (Chapter 35). For more information on this program, please visit the following web site: <https://www.va.gov/education/survivor-dependent-benefits/dependents-education-assistance/> or call 1-888-GIBILL-1 (1-888-442-4551).~~

~~We have withheld VA benefits due to your receipt of military retired pay.~~

~~Applicable Laws and Regulations~~

~~38 C.F.R. 3.31 Commencement of the period of payment.~~

~~38 C.F.R. 3.401 Veterans~~

~~38 C.F.R. 3.700 General~~

~~38 C.F.R. 3.750 Entitlement to concurrent receipt of military retired pay and disability.~~

~~38 C.F.R. 3.751 Statutory awards; retired service personnel.~~

Your monthly entitlement amount is shown below:

Total VA Benefit	Amount Withheld	Amount Paid	Payment Start Date	Reason
\$4,300.06	\$4,045.00	\$255.06	Apr 1, 2022	Original Award
\$4,674.16	\$4,328.00	\$346.16	Dec 1, 2022	Cost of Living Adjustment, Retired Pay Adjustment
\$4,674.16	\$0.00	\$4,674.16	Jul 1, 2023	Retired Pay Adjustment
\$4,573.82	\$0.00	\$4,573.82	Nov 16, 2023	Minor Child Adjustment
\$4,473.48	\$0.00	\$4,473.48	Apr 5, 2025	Minor Child Adjustment
\$4,373.14	\$0.00	\$4,373.14	May 17, 2027	Minor Child Adjustment
\$4,272.80	\$0.00	\$4,272.80	Dec 4, 2028	Minor Child Adjustment
\$4,172.46	\$0.00	\$4,172.46	Dec 2, 2030	Minor Child Adjustment
\$4,072.12	\$0.00	\$4,072.12	Jul 30, 2033	Minor Child Adjustment
\$3,971.78	\$0.00	\$3,971.78	Oct 23, 2035	Minor Child Adjustment

**PRIVATE DBQ ELECTION
submitted to the VA**

Appendix to 10210 Lay Statement - Private DBQ Election

I assert the following three legal privileges and thereby exercise my right to the adjudication of my claim with neither C&P exams nor ACE process C&Ps:

- Privilege #1: Private DBQ Election
- Privilege #2: Exemption from C&Ps
- Privilege #3: Waiver of C&Ps

Privilege #1: Private DBQ Election

The privilege to make a Private DBQ Election arises from M21-1 Part IV, Subpart i, 2.C.1. This policy, which implements the section of 38 USC 5101 amended in 2021 that contains the statutory basis for requiring the VA to weigh private DBQs and C&P examinations equally, states the following:

If the examination facility cancels a pending examination request based on a Veteran's election to submit a privately prepared disability benefits questionnaire (DBQ) in lieu of reporting for a clinical appointment, then follow guidance as it appears in M21-1 Part IV, Subpart i, 2.C.1.e [directing the VA wait for 30 days for submission of the private DBQs].

The effect here is formalization of a process for declining C&P examinations and instead submitting private DBQs as the medical evidence for a claim. This policy declares that canceling or declining C&Ps examinations as part of a private DBQ election **does not** constitute a failure to report requiring the claim to be denied:

Note: Contract examination vendors use clarification requests with a variety of narrative reason values to denote examination appointment scheduling irregularities. The **only** such reason value that may be appropriately considered equivalent to a failure to report for examination, thus warranting application of procedures discussed in M21-1, Part IV, Subpart i, 2.G [referencing 38 CFR 3.655] is *No Show*.

Since I am giving ample notice that I am declining to report for any future C&P examinations, the 'narrative reason value' for cancellation would not be 'No Show.' Also, since my election precedes any C&P appointments, I certainly cannot be treated as a 'No Show' for exams that have not happened yet. It is clear that a Veteran who makes a private DBQ election is not then penalized for canceling or declining C&P examinations. In effect, there is now an alternate pathway to Rating Decisions wherein a private DBQ election permits adjudication of a claim with neither C&P examinations nor ACE process C&Ps.

Privilege #2: Exemption from C&Ps

The plain language of 38 USC 5103A is what establishes the privilege for exemption from C&P examinations. In general, that statute describes the VA's various duties for helping Veterans with their claims. It also contains the following provision at (b)(3):

[The duty-to-assist]. . . ***shall not apply*** if the evidence. . . allows for the. . . highest evaluation assignable in accordance with the evidence. . . as long as such evidence is adequate for rating purposes and sufficient to grant the earliest possible effective date. . . .

If it was the intent of Congress to have the statute applied uniformly in every case without exception, then this highly specific language would be absent. Although the wording does not use the exact term of "exemption," the effect of the language is to provide an exemption. After all, this provision enumerates the criteria for when the parent statute should ***not*** be applied. It should be obvious that the intent here is to relieve the VA of any duty-to-assist tasks that are clearly unnecessary and perhaps counterproductive.

The private DBQs I have submitted meet these exemption requirements completely - that is, they are competent, adequate, and sufficient evidence for evaluation of my claim. In addition, they meet all of the other requirements for private medical evidence found in 38 USC 5125, 38 CFR 3.159 & 3.326, and M21-1 Part V, Subpart ii, 1.A.3. As such, they obviate the need for C&P examinations and the duty-to-assist is therefore truncated with regard to providing them.

Privilege #3: Waiver of C&Ps

The privilege for waiver of C&Ps also originates from within 38 USC 5103A but this time by application of precedential caselaw. The relevant legal concept here is referred to as the "equitable doctrine of waiver." The basis for it is an 1873 decision from the U.S. Supreme Court (Shutte v. Thompson, 82 U.S. 151):

But it is obvious that all the provisions made in the statute. . . were introduced for the protection of the party. . . It is not to be doubted that he may waive them. A party may waive any provision either of a contract or of a statute, intended for his benefit. . . consistent with the rule, that a party may waive any conditions that are intended for his sole benefit. . .

This case remains good law and it applies just as clearly to the VA's duty-to-assist, the provisions of which are unambiguously intended for the sole benefit of Veterans.

The Shutte opinion was quoted and confirmed in 2001 by the U.S. Court of Appeals for Veterans Claims when it decided Janssen v. Principi, 15 Vet. App. 370, a precedent that allows Veterans to waive beneficial duty-to-assist provisions for their compensation claims:

. . . absent some affirmative indication of Congress' intent to preclude waiver. . . [the Court must] presume that statutory provisions are subject to waiver (United States v. Mezzanato, 513 U.S. 196). . . this Court has long accepted the ability of appellants to waive certain procedural rights. . . an appellant can expressly waive. . . due process rights. . . if. . . he wishes to do so (Bowling v. Principi, 15 Vet. App. 1). . . If he believes he can obtain nothing more. . . in terms of development. . . the Court finds no legal reason. . . not to permit him

to make that choice. . . .the Court will permit the. . . .appellant to waive this Court's consideration of any duty-to-assist. . . .rights potentially afforded to him. . . .

The Court goes on to state in the Janssen opinion that waivers must especially be considered when the privilege is asserted explicitly:

Surely an express waiver, such as we have in the instant case, is simply an emphatic way of saying "I choose not to raise this issue". . . .if informed implied waivers are permissible as to this Court's consideration. . . .then so must be expressed waivers. To permit otherwise would be bizarre. . . .

The Court also gave specific consideration in Janssen to waiver of C&P examinations, perhaps because they foresaw that these exams would be critical fulcrums in nearly every future claim:

. . . .the Court understands that there may be compelling reasons why. . . .a claimant may reach an informed conclusion, from the unique position he or she occupies, that further development of the claim may not only be unhelpful, but that it may be harmful to that claim.

The same may be true as to a physical examination or medical opinion provided by VA.He has made clear that he believes that the claim under review has been developed as fully and completely as is necessary (or as much as he wishes it to be). . . .and that he considers further development of the facts. . . .to be of no benefit to him.

The Janssen Court also makes a straightforward description of the conditions under which a Veteran can assert a waiver privilege:

. . . .the appellant must first possess a right, he must have knowledge of that right, and he must intend, voluntarily and freely, to relinquish or surrender that right (United States v. Olano, 507 U.S. 725). . . .if that is his or her clearly stated, informed, and voluntary desire. . . .and has expressed his intention clearly and unequivocally. . . .Nothing further is required (McCall v. U.S. Postal Service, 839 F.2d 664).

Such is the case with the duty-to-assist right to C&P examinations. Therefore, I hereby affirmatively assert my waiver privilege by stating the following: 1) I knowingly possess a statutory right to C&P exams as part of the duty-to-assist; 2) I intend, voluntarily and freely, to relinquish and surrender that right; 3) I have a clear and unequivocal desire to waive C&P examinations for the claims listed at the beginning of this statement.

Right to adjudication without C&Ps

While it is mandatory for the VA to provide C&Ps when indicated, according to the foregoing analysis it is clearly not mandatory for a Veteran to attend those C&Ps in order to prevail on their claim. When the three aforementioned privileges (election, exemption, and waiver) are asserted together, it gives rise to a procedural right to demand adjudication of claims without C&P examinations or ACE process C&Ps. I am hereby exercising that right.

It is reasonable for me to construe that the ordering of any C&P examinations for my claim is a poorly-disguised effort at developing-to-deny, a practice that directly violates many aspects of the governing caselaw and policy, as described by the following:

- Because it would not be permissible for VA to undertake such additional development if a purpose was to obtain evidence against an appellant's case, VA must provide an adequate statement of reasons or bases for its decision to pursue further development where such development reasonably could be construed as obtaining additional evidence for that purpose (Mariano v. Principi, 17 Vet. App. 312).
- Decision makers may not arbitrarily or capriciously refuse to assign weight to a claimant's evidence or develop with the purpose of obtaining evidence to justify a denial of the claim (M21-1 Part V, Subpart ii, 3.B.1).
- . . . additional evidence should not be procured for the sole purpose of denying the veteran's claim (1 Veterans L. Rev. 94).

Significantly, in its own policy at M21-1 Part V, Subpart ii, 1.A.6, the VA has pledged that it will:
. . . award benefits where supported under the facts and law or when the evidence is in relative equipoise or balance while denying only when we must under the facts and law that require it.

The facts and law, the evidence of record, and this private DBQ election require the VA to proceed with adjudicating my claim without developing its own medical evidence in the form of C&P examinations.

**PRIVATE DBQ ELECTION
submitted to the
C&P company**

SECTION III: STATEMENT

(Use this section to submit your statement, or a statement from someone else writing on your behalf)

NOTE: If you would like to submit an additional statement on your own behalf or if you have more than one witness writing on your behalf, use a separate form (VA Form 21-10210) for each statement.

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

From:

██████████ (Veteran)

██████████

██████████ ██████████ ██████████

██████████

To: VA C&P exam contractor

Re: Private DBQ Election

- **I have submitted a Private DBQ Election to the VA for my claim.**
- **I am using private DBQs in lieu of C&P exams.**
- **I decline to report for the C&P exams scheduled with you.**
- **You must now cancel the VA's request for your C&P exams.**
- **You must use 'Private DBQ Election' as the narrative reason for cancellation.**
- **You must not use 'No show' as the narrative reason for cancellation.**
- **You must not use 'Failure to report' as the narrative reason for cancellation.**
- **Refer to M21-1 section IV.i.2.C.1 (attached) for further information.**

**FOIA/PA
request for C-file
and
C&P examiner CVs**

SECTION II: REQUEST FOR INFORMATION ON A PERSON OTHER THAN YOURSELF (Continued)

(If you are seeking information on an individual other than yourself, complete Sections II, III, V and VII or VIII. Complete Section IV, if applicable.)

NOTE: Items 13 through 16 must be completed to inform VA on whom the person is you are requesting the information about.

13. NAME OF THE PERSON YOU ARE REQUESTING INFORMATION ON (First, Middle Initial, Last)

14. SOCIAL SECURITY NUMBER

15. ALIEN REGISTRATION NUMBER (A-number) (if applicable)

16. VA FILE NUMBER (if applicable)

SECTION III: RECORDS YOU ARE SEEKING

(This information is required in order to complete the request)

17. SELECT THE TYPE(S) OF RECORDS YOU ARE REQUESTING, BELOW:

- CLAIMS FILE (C-FILE)
- DD FORM 214
- HUMAN RESOURCE RECORDS
- LIFE INSURANCE BENEFIT RECORDS (If applicable, enter policy number in Section IV, Item 18, Remarks)
- SERVICE TREATMENT RECORDS / MILITARY TREATMENT RECORDS
- LIFE INSURANCE RECORDS
- HOME LOAN BENEFIT RECORDS
- DISABILITY EXAMINATIONS (C & P EXAMS) (If applicable enter date of exam in Section IV, Item 18, Remarks)
- VOCATIONAL REHABILITATION AND EMPLOYMENT RECORDS
- FIDUCIARY SERVICES RECORDS
- MILITARY TO CIVILIAN TRANSITION (TAP) DOCUMENTS
- FINANCIAL RECORDS
- PENSION BENEFIT DOCUMENTS
- EDUCATION BENEFIT RECORDS
- OTHER (Specify)
C&P examiner CVs (see remarks).

SECTION IV: REMARKS

18. REMARKS (If any)

In addition to my C-file, I request all information reasonably attainable by VBA or its contractors relating to the competency, education, training, and expertise of my examiners for C&Ps before the date of this FOIA/PA request. I request the same information for any examinations that occur between the date of this request and the date it is answered. At a minimum (but without limiting the scope of my request), I am seeking a curriculum vitae (CV) for each examiner. These requests are to be submitted by email (contractexam.vbavaco@va.gov; subj: C&P Examination Inquiries) with as much detail as possible, including: examiner name, credentials (e.g., MD, DO, PhD, DMD, DDS, etc.), contract vendor (or VHA), and location (VISN, state, and facility).

SECTION V: WILLINGNESS TO PAY FEES

19. **IMPORTANT:** For the purpose of fees only, FOIA divides requesters into three categories: (1) commercial requesters may be charged fees for searching for records, reviewing the records, and photocopying them; (2) educational, non-commercial scientific institutions, and representatives of the news media are charged for photocopying after the first 100 pages; (3) all other requesters (requesters who do not fall into any of the other two categories) are charged for photocopying after the first 100 pages and for time spent searching for records in excess of two hours. VA charges \$0.15 per single-sided page for photocopying. Actual costs are charged for a format other than paper copies.

An agency may grant fee waivers if the requester successfully demonstrates that the disclosure of information is in the public's interest because it is likely to contribute significantly to the public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester.

- I AM WILLING TO PAY THE APPLICABLE FEES UP TO THE AMOUNT OF \$ 1 .00
- IF YOU BELIEVE YOU ARE ENTITLED TO A FEE WAIVER OR EXPEDITED PROCESSING, INDICATE HERE:

Challenge to the presumption of competency of C&P examiners

SECTION III: STATEMENT**(Use this section to submit your statement, or a statement from someone else writing on your behalf)**

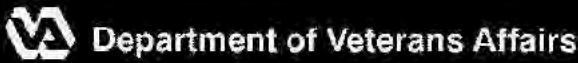
NOTE: If you would like to submit an additional statement on your own behalf or if you have more than one witness writing on your behalf, use a separate form (VA Form 21-10210) for each statement.

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

Challenge to the presumption of competency of C&P examiners

- I challenge the competency of my past C&P examiners, as well as any who assess me in the future (Francway v. Wilkie, 940 F.3d 1304).
- My past C&P exams were inadequate and I expect any future C&Ps will have a similar lack of quality. The exams were completed in a cursory manner that trivialized, minimized, and ignored my signs and symptoms. I have requested copies of these exams. Only when I receive and review them will I be able to criticize them with more specificity. Until then, I allege that any past or future C&P exam present in my C-file contains harmful errors that include, but are not limited to, at least one of the following examiner deficiencies:
 - not qualified to perform the exam, or less qualified than another examiner of record.
 - failed to consider my credible testimony and competent lay observations regarding signs and symptoms, onset, chronicity, continuity, or history.
 - failed to provide an adequate rationale for a conclusion.
 - drew a conclusion about a non-medical fact.
 - relied on an inaccurate factual premise.
 - gave an inconclusive opinion without explaining why a conclusion could not be reached.
 - used an improperly high evidentiary standard.
 - did not address all legal theories of entitlement to service connection.
 - did not provide the detail required by 38 CFR 4.40 and 4.45 when describing the effects of pain or other impairments on joint motion.
 - did not properly perform all of the examination components required by 38 CFR 4.59 for joint assessment.
- Further, I expressly rebut the presumption of competence - that is, "qualified through training, education, or experience" - of any C&P examiners who have submitted or will submit any evidence at any time to anyone with regard to my claims with the VA (38 CFR 3.159(a)(1); Francway v. Wilkie, 940 F.3d 1304). Under the 'Duty to Assist,' C&P examinations are required to be "thorough and contemporaneous" (38 USC 5103A; Pond v. West, 12 Vet. App. 341). A C&P examination must also be "adequate" in that it is "based upon consideration of the veteran's prior medical history and examinations and also describes the disability in sufficient detail so that the evaluation of the claimed disability will be a fully informed one" (Barr v. Nicholson, 21 Vet. App. 303). Unfortunately, much more often than not, C&P examinations are neither thorough, contemporaneous, or adequate, nor do they have any of the other essential attributes described in the governing statutes, caselaw, and regulations. C&P examiners do not merit the general presumption that they enjoy under the law.

526EZ claim form



VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 14 before completing the form. Use this form to determine your eligibility for compensation. For more information, you can contact us online through Ask VA: <https://ask.va.gov>. Ask us a question online or call us toll-free at 1-800-827-1000 (TTY: 711). If you prefer you may complete and submit the form online at www.va.gov. VA forms are available at www.va.gov/vaforms.

1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS THAT APPLIES TO YOU. **NOTE:** Your claim will be processed as described on pages 1 through 8 unless one of the following special programs is selected. See Instruction pages 1 through 3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process.

- FDC PROGRAM STANDARD CLAIM PROCESS
 IDES (Select this option *only* if you have been referred to the IDES Program by your Military Service Department)
 BDD Program Claim (Select this option *only* if you meet the criteria for the BDD Program specified on Instruction Page 5)

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

(If claim is not an original claim, only Section I, IV (if applicable), V and a signature are required)

NOTE: You may *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly, insert one letter per box, and completely fill in each applicable check box to help expedite processing of the form.

2. VETERAN/SERVICEMEMBER'S NAME (First, Middle Initial, Last)

██████████

3. VETERAN'S SOCIAL SECURITY NUMBER (SSN)

██████████

4. HAVE YOU EVER FILED A CLAIM WITH VA?

YES NO (If "Yes," provide your file number in Item 5)

5. VA FILE NUMBER

██████████

6. DATE OF BIRTH (MM-DD-YYYY)

██████████

7. VETERANS SERVICE NUMBER (if applicable)

8. BDD CLAIM ONLY: PROVIDE THE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY (MM-DD-YYYY)

9. TELEPHONE NUMBER (Optional) (Include Area Code)

██████████

Enter International Phone Number (If applicable)

10. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street ██████████

Apt./Unit Number ██████████ City ██████████

Country US ZIP Code/Postal Code ██████████

11. E-MAIL ADDRESS (Optional) I agree to receive electronic correspondence from VA in regards to my claim.

██████████

12. IF YOU ARE CURRENTLY A VA EMPLOYEE, CHECK THE BOX (Includes Work Study/Internship) (If you are not a VA employee skip to Section II, if applicable)

SECTION II: CHANGE OF ADDRESS

NOTE: If you are temporarily or permanently changing your address, complete Items 13A through 13C.

13A. TYPE OF ADDRESS CHANGE (Complete if applicable) (Check only one box)

TEMPORARY PERMANENT

13B. NEW ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

13C. EFFECTIVE DATE(S) OF NEW ADDRESS (If your change of address is **temporary**, complete both the beginning and ending date of your temporary address) (If your change of address is **permanent**, please enter your effective date in the beginning date only)

BEGINNING DATE: Month Day Year ENDING DATE: Month Day Year

SECTION V: CLAIM INFORMATION (Continued)
 (For additional space, use Section XIII: Claim Information (Addendum))

CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation, burn pits)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENERD
***** ATTENTION! ***** Please read the enclosed Private DBQ Election.	***** ATTENTION! ***** Please read the enclosed Private DBQ Election.	***** ATTENTION! ***** Please read the enclosed Private DBQ Election.	
1. LEFT SHOULDER CONDITION - to include left shoulder osteoarthritis (DC 5003-5201) rated 20 percent effective 03/01/2022 (retirement date). Private DBQs enclosed.		Direct service connection.	
2. LEFT LEG NERVE CONDITION - to include left sciatic radiculopathic neuritis (DC 8620) rated 40 percent effective 03/01/2022 (retirement date). Private DBQs enclosed.		Direct service connection.	
3. RIGHT ARM NERVE CONDITION - to right arm ulnar neuritis (DC 8616) rated 30 percent effective 03/01/2022 (retirement date). Private DBQs enclosed.		Direct service connection.	
4. PERMANENT & TOTAL (P&T) Status - effective 03/01/2022 (retirement date). Private DBQs enclosed.		Entitlement from all service connected conditions.	
17. LIST VA MEDICAL CENTER(S) (VAMC) AND DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITIES (MTF) WHERE YOU RECEIVED TREATMENT AFTER DISCHARGE FOR YOUR CLAIMED DISABILITY(IES) LISTED IN ITEM 16 AND PROVIDE APPROXIMATE BEGINNING DATE (Month and Year) OF TREATMENT. IF ADDITIONAL SPACE IS NEEDED ATTACH A SEPARATE SHEET AND INCLUDE YOUR NAME, SOCIAL SECURITY NUMBER AND ITEM NUMBER.			
NOTE: If treatment began from 2005 to present, you do not need to provide dates in Item 17B.			
A. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY	B. DATE OF TREATMENT (MM-YYYY)	C. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT	
		<input type="checkbox"/> Don't have date	
		<input type="checkbox"/> Don't have date	
		<input type="checkbox"/> Don't have date	
NOTE: IF YOU WISH TO CLAIM ANY OF THE FOLLOWING, COMPLETE AND ATTACH THE REQUIRED FORM(S) AS STATED BELOW. (VA forms are available at www.va.gov/vaforms)			

Clarification of issues being claimed

SECTION III: STATEMENT**(Use this section to submit your statement, or a statement from someone else writing on your behalf)**

NOTE: If you would like to submit an additional statement on your own behalf or if you have more than one witness writing on your behalf, use a separate form (VA Form 21-10210) for each statement.

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

Clarification of issues being claimed**A. Withdrawal of certain issues:**

There is a pending 526EZ claim that was filed on 12/30/2022. I request withdrawal of the issues listed below that were included on that claim from consideration for VA disability compensation. Please stop processing these issues:

- Bilateral myopia
- Bilateral hearing loss
- Chronic headaches
- Left epididymitis
- Allergic dermatitis of upper left eyelid
- Trochanteric bursitis

B. New issues:

I have filed a second 526EZ claim with additional issues for consideration. Please combine these two 526EZ claims together, along with the 686c Dependency claim I have filed, so that they result in a single Rating Decision.

C. Pending issue clarification:

There are several pending claim issues from the 526EZ filed on 12/30/2022 that I would like to clarify. For each of the issues listed below, please adjudicate it according to the claim clarification language that follows each item. Please treat these statements as if they were contained on the 526EZ issue list when it was filed on 12/30/2023. These statements provide a more clear and detailed description of the disability compensation benefits that I am seeking. I hope that these clarifications provide some assistance in adjudicating my claim.

- Pending issue #1:
Right elbow contusion and chronic pain.
- Clarification:
RIGHT ELBOW CONDITION (to include right elbow epicondylitis and bicipital tendonitis) DC 5208 rated 20% and DC 5213 rated 20% effective 03/01/2022 (retirement date; private DBQs included).

(continued on next page)

SECTION III: STATEMENT (Continued)**(Use this section to submit your statement, or a statement from someone else writing on your behalf)**

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

- Pending issue #2:
 - Right foot (claimed as chronic bilateral foot pain).
 - Left foot (claimed as chronic bilateral foot pain).
- Clarification:
BILATERAL FOOT CONDITION (to include bilateral foot plantar fasciitis DC 5269) rated 10% effective 03/01/2022 (retirement date; private DBQs included).

- Pending issue #3:
Chronic left hip pain.
- Clarification:
LEFT HIP CONDITION (to include left hip osteoarthritis): FLEXION (DC 5003-5252) rated 30%; EXTENSION (DC 5003-5251) rated 10%; and ABDUCTION THIGH IMPAIRMENT (DC 5003-5253) rated 20% effective 03/01/2022 (retirement date; private DBQs included).

*(continued in appendix)***SECTION IV: WITNESS CONTACT INFORMATION****(Complete Section IV and V if the statement in Section III is from someone else writing on your behalf)**

18. WITNESS NAME (First, Middle Initial, Last)

19. RELATIONSHIP TO VETERAN (Check all that apply)

- SERVED WITH CLAIMANT FAMILY/FRIEND OF CLAIMANT COWORKER/SUPERVISOR OF CLAIMANT
 OTHER (Specify)

20. TELEPHONE NUMBER (Include Area Code)

21. E-MAIL ADDRESS

Enter International Phone Number
(If applicable)**SECTION V: CERTIFICATION OF STATEMENT AND SIGNATURE****I CERTIFY THAT** I have completed this statement and that its information is true and correct to the best of my knowledge and belief.

SIGNATURE (REQUIRED)

22B. DATE SIGNED

Month Day Year
02-13-2023**PENALTY:** The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact knowing it to be false, or for fraudulent receipt of any document to which you are not entitled.**PRIVACY ACT NOTICE:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, Vocational Rehabilitation and Employment Records-VA, published in the Federal Register. Your obligation to respond is voluntary.**RESPONDENT BURDEN:** This form is used to submit a statement that supports a claim already pending or already established with VA. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Appendix to 10210 Lay statement - Clarification of issues being claimed

- Pending issue #4:

Right hip contusion and chronic pain.

- Clarification:

RIGHT HIP CONDITION (to include right hip osteoarthritis): FLEXION (DC 5003-5252) rated 30%; EXTENSION (DC 5003-5251) rated 10%; and ABDUCTION THIGH IMPAIRMENT (DC 5003-5253) rated 20% effective 03/01/2022 (retirement date; private DBQs included).

- Pending issue #5:

Chronic cervical pain.

- Clarification:

NECK CONDITION (to include cervical spine strain DC 5237): evaluation of 20% effective 03/01/2022 (retirement date; private DBQs included).

- Pending issue #6:

Chronic lower back pain.

- Clarification:

BACK CONDITION (to include thoracolumbar spine degenerative arthritis DC 5242) rated 40% effective 03/01/2022 (retirement date; private DBQs included).

- Pending issue #7:

Right knee (claimed as chronic pain, bilateral knees).

- Clarification:

RIGHT KNEE CONDITION (to include right knee osteoarthritis with ACL tear): FLEXION (DC 5003-5260) rated 20%; EXTENSION (DC 5003-5261) rated 20%; and INSTABILITY (DC 5003-5257) rated 10% effective 03/01/2022 (retirement date; private DBQs included).

- Pending issue #8:

Left knee (claimed as chronic pain, bilateral knees)

- Clarification:

LEFT KNEE CONDITION (to include left knee osteoarthritis): FLEXION (DC 5003-5260) rated 20% and EXTENSION (DC 5003-5261) rated 20% effective 03/01/2022 (retirement date; private DBQs included).

- Pending issue #9:

Chronic right shoulder pain

- Clarification:

RIGHT SHOULDER CONDITION (to include right shoulder osteoarthritis with rotator cuff tear DC 5003-5201) rated 20% effective 03/01/2022 (retirement date; private DBQs included).

- Pending issue #10:

Tinnitus

- Clarification:

TINNITUS DC 6260 rated 10% effective 03/01/2022 (retirement date; private DBQs included).

Nexus letters

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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. Please note that this questionnaire is for disability evaluation, not for treatment purposes.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA21 2507, 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: Remark 1.

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE 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 will likely provide no additional relevant evidence.
- Review of available records in conjunction with an interview with the Veteran (without in person or 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
- VA claims file (hard copy paper C file)
- VA e folder (VBMS or Virtual VA)
- CPRS
- Other (please identify other evidence reviewed):
- No records were reviewed

Remark 2.

EVIDENCE COMMENTS:

Remark 2.

NOTE: This form is only for use by VHA staff or contract examiners.

This exam is for:

- Tinnitus only (audiologist or non audiologist clinician) If this exam is for tinnitus only, complete section 2 only. Otherwise complete entire form
- Hearing loss and/or tinnitus (audiologist, performing current exam)
- Hearing loss and/or tinnitus (audiologist or non audiologist clinician, using audiology report of record that represents Veteran's current condition)

If using audiology report of record, date audiology exam was performed: Remark 3.

SECTION 1: HEARING LOSS (HL)

Note: All testing must be conducted in accordance with the following instructions to be valid for VA disability evaluation purposes.

Instructions: An examination of hearing impairment must be conducted by a state licensed audiologist and must include a controlled speech discrimination test (specifically, the Maryland CNC recording) and a puretone audiometry test in a sound isolated booth that meets American National Standards Institute standards (ANSI S3.1.1999 [R2004]) for ambient noise. Measurements will be reported at the frequencies of 500, 1000, 2000, 3000, and 4000 Hz.

The examination will include the following tests: Puretone audiometry by air conduction at 250, 500, 1000, 2000, 3000, 4000, 6000 Hz and 8000 Hz, and by bone conduction at 250, 500, 1000, 2000, 3000, and 4000 Hz, spondee thresholds, speech discrimination using the recorded Maryland CNC Test, tympanometry and acoustic reflex tests (ipsilateral and contralateral), and, when necessary, Stenger tests. Bone conduction thresholds are measured when the air conduction thresholds are poorer than 15 dB HL. A modified Hughson Westlake procedure will be used with appropriate masking. A Stenger must be administered whenever puretone air conduction thresholds at 500, 1000, 2000, 3000, and 4000 Hz differ by 20 dB or more between the two ears.

Maximum speech discrimination will be reported with the 50 word VA approved recording of the Maryland CNC test. The starting presentation level will be 40 dB re SRT. If necessary, the starting level will be adjusted upward to obtain a level at least 5 dB above the threshold at 2000 Hz, if not above the patient's tolerance level.

The examination will be conducted without the use of hearing aids. Both ears must be examined for hearing impairment even if hearing loss in only one ear is at issue.

When speech discrimination is 92% or less, a performance intensity function must be obtained.

A comprehensive audiological evaluation should include evaluation results for puretone thresholds by air and bone conduction (500 8000 Hz), speech reception thresholds (SRT), speech discrimination scores, and acoustic immittance with acoustic reflexes (ipsilateral and contralateral reflexes). Tests for non organicity must be performed when indicated.

1. OBJECTIVE FINDINGS

A. PURETONE THRESHOLDS IN DECIBELS (AIR CONDUCTION):

Instructions: Measure and record puretone threshold values in decibels at the indicated frequencies (air conduction). Report the decibel (dB) value, which ranges from 10 dB to 105 dB, for each of the frequencies. Add a plus behind the decibel value when a maximum value has been reached with a failure of response from the Veteran. In those circumstances where the average includes a failure of response at either the maximum allowable limit (105 dB) or the maximum limits of the audiometer, use this maximum decibel value of the failure of response in the puretone threshold average calculation.

If the Veteran could not be tested (CNT), enter CNT and state the reason why the Veteran could not be tested. Clearly inaccurate, invalid or unreliable test results should not be reported.

The puretone threshold at 500 Hz is not used in calculating the puretone threshold average for evaluation purposes but is used in determining whether or not for VA purposes, hearing impairment reaches the level of a disability. The puretone threshold average requires the decibel levels of each of the required frequencies (1000 Hz, 2000 Hz, 3000 Hz, and 4000 Hz) be recorded for the test to be valid for determination of a hearing impairment.

RIGHT EAR

A	B	C	D	E	F	G	
500 Hz*	1000 Hz*	2000 Hz*	3000 Hz*	4000 Hz*	6000 Hz*	8000 Hz*	Avg Hz (B E)**

LEFT EAR

A	B	C	D	E	F	G	
500 Hz*	1000 Hz*	2000 Hz*	3000 Hz*	4000 Hz*	6000 Hz*	8000 Hz*	Avg Hz (B E)**

*The puretone threshold at 500 Hz is not used in determining the evaluation but is used in determining whether or not a ratable hearing loss exists.

**The average of B, C, D, and E.

***CNT Could Not Test

B. WERE THERE ONE OR MORE FREQUENCY(IES) THAT COULD NOT BE TESTED?

YES NO *If yes, enter CNT in the box for frequency(ies) that could not be tested, and explain why testing could not be done:*

C. VALIDITY OF PURETONE TEST RESULTS:

- Test results are valid for rating purposes.
- Test results are not valid for rating purposes (not indicative of organic hearing loss).
If invalid, provide reason:

D. SPEECH DISCRIMINATION SCORE (MARYLAND CNC WORD LIST)

Instructions on pausing: Examiners should pause when necessary during speech discrimination tests, in order to give the Veteran sufficient time to respond. This will ensure that the test results are based on actual hearing loss rather than on the effects of other problems that might slow a Veteran's response. There are a variety of problems that might require pausing, for example, the presence of cognitive impairment. It is up to the examiner to determine when to use pausing and the length of the pauses.

RIGHT EAR	%
LEFT EAR	%

E. APPROPRIATENESS OF USE OF WORD RECOGNITION SCORE (MARYLAND CNC WORD LIST):

RIGHT EAR:

IS WORD DISCRIMINATION SCORE AVAILABLE?

YES NO

Use of speech discrimination score is appropriate for this Veteran.

The use of the speech discrimination score is not appropriate for this Veteran because of language difficulties, cognitive problems, inconsistent speech discrimination scores, etc., that make combined use of puretone average and speech discrimination scores inappropriate.

LEFT EAR:

IS WORD DISCRIMINATION SCORE AVAILABLE?

YES NO

Use of speech discrimination score is appropriate for this Veteran.

The use of the speech discrimination score is not appropriate for this Veteran because of language difficulties, cognitive problems, inconsistent speech discrimination scores, etc., that make combined use of puretone average and speech discrimination scores inappropriate.

F. AUDIOLOGIC FINDINGS

Summary of Immittance (Tympanometry) Findings:

	RIGHT EAR		LEFT EAR	
ACOUSTIC IMMITTANCE	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
IPSILATERAL ACOUSTIC REFLEXES	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
CONTRALATERAL ACOUSTIC REFLEXES	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
UNABLE TO INTERPRET REFLEXES DUE TO ARTIFACT		<input type="checkbox"/>		<input type="checkbox"/>
UNABLE TO OBTAIN / MAINTAIN SEAL		<input type="checkbox"/>		<input type="checkbox"/>

2. DIAGNOSIS

RIGHT EAR

- Normal hearing
- Conductive hearing loss ICD CODE:
- Mixed hearing loss ICD CODE:
- Sensorineural hearing loss (in frequency range of 500 4000 Hz)* ICD CODE:
- Sensorineural hearing loss (in frequency range of 6000 Hz or higher frequencies)** ICD CODE:
- Significant changes in hearing thresholds in service*** ICD CODE:

LEFT EAR

- Normal hearing
- Conductive hearing loss ICD CODE:
- Mixed hearing loss ICD CODE:
- Sensorineural hearing loss (in frequency range of 500 4000 Hz)* ICD CODE:
- Sensorineural hearing loss (in frequency range of 6000 Hz or higher frequencies)** ICD CODE:
- Significant changes in hearing thresholds in service***

NOTES:

*The Veteran may have hearing loss at a level that is not considered to be a disability for VA purposes. This can occur when the auditory thresholds are greater than 25 dB at one or more frequencies in the 500 4000 Hz range.

** The Veteran may have impaired hearing, but it does not meet the criteria to be considered a disability for VA purposes. For VA purposes, the diagnosis of hearing impairment is based upon testing at frequency ranges of 500, 1000, 2000, 3000, and 4000 Hz. If there is no HL in the 500 4000 Hz range, but there is HL above 4000 Hz, check this box.

***The Veteran may have a significant change in hearing threshold in service, but it does not meet the criteria to be considered a disability for VA purposes. (A significant change in hearing threshold may indicate noise exposure or acoustic trauma.)

3. ETIOLOGY

ETIOLOGY OPINION NOT INDICATED AS: SERVICE CONNECTED CONDITION VBA DID NOT REQUEST ETIOLOGY

RIGHT EAR

WAS THERE A PERMANENT POSITIVE THRESHOLD SHIFT (WORSE THAN REFERENCE THRESHOLD) GREATER THAN NORMAL MEASUREMENT VARIABILITY AT ANY FREQUENCY BETWEEN 500 AND 6000 HZ FOR THE RIGHT EAR?

YES NO

OPINION PROVIDED FOR THE RIGHT EAR:

YES NO

3. ETIOLOGY (continued)

RIGHT EAR (continued)

IF PRESENT, IS THE VETERAN'S RIGHT EAR HEARING LOSS AT LEAST AS NOT (50% PROBABILITY OR GREATER) CAUSED BY OR A RESULT OF AN EVENT IN MILITARY SERVICE?

- YES
- NO
- CANNOT DETERMINE A MEDICAL OPINION REGARDING THE ETIOLOGY OF THE VETERAN'S RIGHT EAR HEARING LOSS WITHOUT RESORTING TO SPECULATION:

RATIONALE (Provide rationale for either a yes, no answer or speculation reason):

DID HEARING LOSS EXIST PRIOR TO SERVICE?

- YES
- NO

IF YES, WAS THE PRE EXISTING HEARING LOSS AGGRAVATED BEYOND NORMAL PROGRESSION IN MILITARY SERVICE?

- YES
- NO

PROVIDE RATIONALE FOR BOTH YES OR NO:

LEFT EAR

WAS THERE A PERMANENT POSITIVE THRESHOLD SHIFT (WORSE THAN REFERENCE THRESHOLD) GREATER THAN NORMAL MEASUREMENT VARIABILITY AT ANY FREQUENCY BETWEEN 500 AND 6000 HZ FOR THE LEFT EAR?

- YES
- NO

OPINION PROVIDED FOR THE LEFT EAR:

- YES
- NO

IF PRESENT, IS THE VETERAN'S LEFT EAR HEARING LOSS AT LEAST AS NOT (50% PROBABILITY OR GREATER) CAUSED BY OR A RESULT OF AN EVENT IN MILITARY SERVICE?

- YES
- NO
- CANNOT DETERMINE A MEDICAL OPINION REGARDING THE ETIOLOGY OF THE VETERAN'S LEFT EAR HEARING LOSS WITHOUT RESORTING TO SPECULATION:

RATIONALE (Provide rationale for either a yes, no answer or speculation reason):

DID HEARING LOSS EXIST PRIOR TO SERVICE?

- YES
- NO

IF YES, WAS THE PRE EXISTING HEARING LOSS AGGRAVATED BEYOND NORMAL PROGRESSION IN MILITARY SERVICE?

- YES
- NO

PROVIDE RATIONALE FOR BOTH YES OR NO:

4. FUNCTIONAL IMPACT OF HEARING LOSS

NOTE: Ask the Veteran to describe in his or her own words the effects of disability (i.e., the current complaint of hearing loss on occupational functioning and daily activities). Document the Veteran's response without opining on the relationship between the functional effects and the level of impairment (audiogram) or otherwise characterizing the response. Do not use handicap scales.

DOES THE VETERAN'S HEARING LOSS IMPACT ORDINARY CONDITIONS OF DAILY LIFE, INCLUDING ABILITY TO WORK?

- YES
- NO

IF YES, DESCRIBE IMPACT IN THE VETERAN'S OWN WORDS:

5. REMARKS, IF ANY, PERTAINING TO HEARING LOSS:

SECTION 2: TINNITUS

1. MEDICAL HISTORY

DOES THE VETERAN REPORT RECURRENT TINNITUS?

YES NO

DATE AND CIRCUMSTANCES OF ONSET OF TINNITUS:

Remark 4.

2. ETIOLOGY OF TINNITUS

SELECT ANSWER BELOW AND PROVIDE RATIONALE WHERE REQUESTED:

ETIOLOGY OPINION NOT INDICATED AS: SERVICE CONNECTED CONDITION VBA DID NOT REQUEST ETIOLOGY

THE VETERAN HAS A DIAGNOSIS OF CLINICAL HEARING LOSS, AND HIS OR HER TINNITUS IS AT LEAST AS LIKELY AS NOT (50% PROBABILITY OR GREATER) A SYMPTOM ASSOCIATED WITH THE HEARING LOSS, AS TINNITUS IS KNOWN TO BE A SYMPTOM ASSOCIATED WITH HEARING LOSS.

LESS LIKELY THAN NOT (LESS THAN 50% PROBABILITY) A SYMPTOM ASSOCIATED WITH THE VETERAN'S HEARING LOSS
RATIONALE:

AT LEAST AS LIKELY AS NOT (50% PROBABILITY OR GREATER) CAUSED BY OR A RESULT OF MILITARY NOISE EXPOSURE
RATIONALE:

Remark 5.

AT LEAST AS LIKELY AS NOT (50% PROBABILITY OR GREATER) DUE TO A KNOWN ETIOLOGY (*such as traumatic brain injury*)
RATIONALE:

LESS LIKELY THAN NOT (LESS THAN 50% PROBABILITY) CAUSED BY OR A RESULT OF MILITARY NOISE EXPOSURE
RATIONALE:

CANNOT PROVIDE A MEDICAL OPINION REGARDING THE ETIOLOGY OF THE VETERAN'S TINNITUS WITHOUT RESORTING TO SPECULATION
REASON SPECULATION REQUIRED:

3. FUNCTIONAL IMPACT OF TINNITUS

NOTE: Ask the Veteran to describe in his or her own words the effects of disability (i.e., the current complaint on occupational functioning and daily activities). Document the Veteran's response without opining on the relationship between the functional effects and the level of impairment (audiogram) or otherwise characterizing the response. Do not use handicap scales.

DOES THE VETERAN'S TINNITUS IMPACT ORDINARY CONDITIONS OF DAILY LIFE, INCLUDING ABILITY TO WORK?

YES NO

IF YES, DESCRIBE IMPACT IN THE VETERAN'S OWN WORDS

Remark 6.

4. REMARKS, IF ANY, PERTAINING TO TINNITUS

Remark 7.

All remarks are in the first appendix.

Additional notes for examining physician:

[Redacted text block containing physician notes]

SECTION 3: PHYSICIAN'S CERTIFICATION AND SIGNATURE

plete and current.

PRINTED NAME

MD

PHONE AND FAX NUMBER

ADDRESS

NOTE - VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the veteran's application.

IMPORTANT Audiologist/Physician please fax the completed form to _____ (VA Regional Office FAX No.)

NOTE A list of VA Regional Office FAX Numbers can be found at www.benefits.va.gov/disability/exams or obtained by calling 1 800 827 1000.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Appendix to DBQ and medical opinion

Service connection for **TINNITUS**

Remark 1. Description of examination

Background

This DBQ and medical opinion is private evidence from a physician Independent Veteran Examiner (IVE). Mr. [REDACTED] the Veteran claimant, resides in [REDACTED]. He traveled from there to my clinic [REDACTED]. I performed a comprehensive face-to-face history and physical exam.

Introduction of examiner - [REDACTED] MD

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] I have developed a specialized skill in Veteran medical issues and VA disability policy. In my reports I strive to meet or exceed the many meticulous requirements arrayed across the various regulations, statutes, and court precedents that apply. I take great care to produce assessments that are thorough, contemporaneous, technically adequate, and fully informed. This field of work has significant scientific and philosophical challenges. I meet these with a particular expertise that arises from my advanced education, extensive training in multiple domains, and diverse professional experience. The enclosed curriculum vitae describes my credentials in further detail.

Credibility and competence of the Veteran - Mr. [REDACTED]

During my detailed clinical interview, I was able to make an accurate judgment of his overall level of credibility as well as his competence to make appropriate lay observations about medical conditions. The demeanor of his communication throughout the interview was always trustworthy. For example, I did not detect any misrepresentation, embellishment, or exaggeration, nor any effort to misdirect or deceive me in any way. Instead, his statements were coherent, logical, and forthright. They also matched my independent observations. His review of relevant events was consistent with the known facts and circumstances of his military service. In addition, his description of the symptoms and course of his conditions was entirely compatible with the natural history that is generally known to medicine. I also noted that in the course of his life, including his military service, Mr. [REDACTED] has been successfully entrusted with many positions of great responsibility and authority, indicating technical skill as well as a respect for the truth. After taking these things into consideration, it is my opinion to a high degree of certainty that he is eminently credible, and further that he is competent to make medical observations befitting a layperson. I therefore treated his reports as a reliable source of data in my analysis.

Remark 2. Evidence review

My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C-file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review, *Nieves-Rodriguez v. Peake*, 22 Vet. App. 295, which clearly states that private examiners are not required to review any particular set of records or even to review the C-file at all:

...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.

Such is the case where entitlement to service connection is clearly supported in the records available for my review. This is described in more detail in the rationale section below in Remark 5.

Remark 3. Date audiology exam was performed.

07/08/2021 while on active duty.

Remark 4. Medical history

See rationale in remark 5. Onset after accidental noise exposure to helicopter.

Remark 5. Service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating these conditions in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disabilities considered holistically.

The STRs clearly indicate diagnosis of tinnitus on active duty. The audiology exam on 07/08/2021 makes a specific notation that Mr. [REDACTED] reported tinnitus at the time of that exam. That audiology report is appended. The tinnitus first developed after accidental extreme exposure to nearby helicopter engine noise without hearing protection while deployed to Afghanistan in 2015. The initial manifestation of this condition never fully resolved after it arose on active duty. It remained symptomatic and developed into the chronic disability found today.

According to my record review and a detailed history taken from Mr. [REDACTED] there has been continuity of symptoms from service to present. In addition, the development and progression of this condition as presented in the particular case of Mr. [REDACTED] is completely consistent with sound general medical principles as well as the consensus of expert medical opinion on the subject. It is well known in the current credible professional peer-reviewed medical literature that tinnitus may result from even one event of extreme acoustic injury (citations 1 through 4).

Each of the opinions below was rendered after reaching a certainty of **at least as likely as not - that is, the likelihood has at least a 50 percent probability, or the evidence is in approximate balance or nearly equal if not higher** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a current chronic disability of TINNITUS.
- Mr. [REDACTED] had in-service extreme noise exposure.
- The TINNITUS noted on the in-service audiology exam on 07/08/2021 has been persistent from the time of the in-service extreme noise exposure up until the present.
- The current TINNITUS was incurred in the in-service illness of TINNITUS.
- A causal nexus has been established for direct service connection of TINNITUS.

Remark 5. Functional impact

Mr. [REDACTED] tinnitus interferes with all sedentary and physical occupations due to distraction and lack of concentration due to a constant ringing-in-the-ears sensation that has intermittent fluctuations of intensity.

Remark 6. Citations

1. Humes L, Joellenbeck L, Durch J. Noise and Military Service: Implications for Hearing Loss and Tinnitus. Washington, DC: National Academies Press; 2005.
2. Liberman MC, Mulroy MJ. Acute and chronic effects of acoustic trauma: Cochlear pathology and auditory nerve pathophysiology. In: Hamernik RP, Henderson D, Salvi R, editors. New Perspectives on Noise-Induced Hearing Loss. 1982. pp. 105–136.
3. Alamgir H, Turner CA, Wong NJ, Cooper SP, Betancourt JA, Henry J, Senchak AJ, Hammill TL, Packer MD. The impact of hearing impairment and noise-induced hearing injury on quality of life in the active-duty military population: challenges to the study of this issue. Mil Med Res. 2016 Apr 12;3:11. Doi: 10.1186/s40779-016-0082-5. eCollection 2016. Review. PubMed PMID: 27076916; PubMed Central PMCID: PMC4830069.
4. Yankaskas K. Prelude: noise-induced tinnitus and hearing loss in the military. Hear Res. 2013 Jan;295:3-8. doi: 10.1016/j.heares.2012.04.016. Epub 2012 May 2. PubMed PMID: 22575206.

Remark 7. Clarifications

Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as

the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective - that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and ***MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION*** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet. App. 259). In addition, I ask that clarification requests regarding my report not be directed to a C&P examiner, especially one of lesser credentials, who has no prior familiarity with Mr. [REDACTED] or this disability. Since I am readily available and responsive, such action by the VA "reasonably could be construed" as procuring evidence "for the sole purpose of denying the veteran's claim," also known as "developing to deny," an administrative practice that is rightly forbidden since it is hostile to Mr. [REDACTED] claim (Mariano v. Principi 17 Vet. App. 312; 1 Veterans L. Rev. 94; M21-1 section V.ii.3.B.1.a).

Author's direct contact information:

[REDACTED] MD
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

**INTERNAL VETERANS AFFAIRS USE
MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE**

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

[REDACTED]

[REDACTED]

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 VA 21 2507, 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: Remark 1,

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 will likely provide no additional relevant evidence.
- Review of available records in conjunction with an interview with the Veteran (without in person or 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
- VA claims file (hard copy paper C file)
- VA e folder
- VA electronic health record
- Other, please identify other evidence reviewed:
- No records were reviewed

Remark 2,

Evidence Comments:

Remark 2.

SECTION I - DEFINITIONS

AGGRAVATION OF PREEXISTING NONSERVICE CONNECTED DISABILITIES: A PREEXISTING INJURY OR DISEASE WILL BE CONSIDERED TO HAVE BEEN AGGRAVATED BY ACTIVE MILITARY, NAVAL, OR AIR SERVICE, WHERE THERE IS AN INCREASE IN DISABILITY DURING SUCH SERVICE, UNLESS THERE IS A SPECIFIC FINDING THAT THE INCREASE IN DISABILITY IS DUE TO THE NATURAL PROGRESS OF THE DISEASE.

AGGRAVATION OF NONSERVICE CONNECTED DISABILITIES: ANY INCREASE IN SEVERITY OF A NONSERVICE CONNECTED DISEASE OR INJURY THAT IS PROXIMATELY DUE TO OR THE RESULT OF A SERVICE CONNECTED DISEASE OR INJURY, AND NOT DUE TO THE NATURAL PROGRESS OF THE NONSERVICE CONNECTED DISEASE, WILL BE SERVICE CONNECTED.

SECTION II - RESTATEMENT OF REQUESTED OPINION

2A. INSERT REQUESTED OPINION FROM GENERAL REMARKS:

Back condition service connection; Remark 3.

2B. INDICATE TYPE OF EXAM FOR WHICH OPINION HAS BEEN REQUESTED (e.g. skin diseases): Back.

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- 3A. THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 3B. THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (less than 50 percent probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

3C. RATIONALE:

Remark 4.

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

- 4A. THE CLAIMED CONDITION IS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.
- 4B. THE CLAIMED CONDITION IS LESS LIKELY THAN NOT (less than 50 percent probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.

4C. RATIONALE:

Remark 5.

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

- 5A. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 5B. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS CLEARLY AND UNMISTAKABLY NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

5C. RATIONALE:

Not applicable.

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. CAN YOU DETERMINE A BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition)?

- YES NO

IF "YES" TO QUESTION 6A, ANSWER THE FOLLOWING:

I. DESCRIBE THE BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition):

Not applicable.

II. PROVIDE THE DATE AND NATURE OF THE MEDICAL EVIDENCE USED TO PROVIDE THE BASELINE:

Not applicable.

III. IS THE CURRENT SEVERITY OF THE (claimed condition/diagnosis) GREATER THAN THE BASELINE?

- YES NO

IF YES, WAS THE VETERAN'S (claimed condition/diagnosis) AT LEAST AS LIKELY AS NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY (insert "service connected condition")?

- YES (provide rationale in section 6B.)
- NO (provide rationale in section 6B.)

Remark 2. Evidence review

My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C-file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review which clearly states that private examiners are not required to review any particular set of records or even to review the C-file at all (Nieves-Rodriguez v. Peake, 22 Vet. App. 295):

...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.

Such is the case where entitlement to service connection is clearly supported in the records available for my review. This is described in more detail in the rationale section below.

Remark 3. Question requiring a medical opinion

Has a causal nexus for service connection been established for the **BACK CONDITION?**

Remark 4. Direct service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating this condition in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disability considered holistically.

The STRs clearly indicate diagnosis of THORACOLUMBAR SPINE DEGENERATIVE ARTHRITIS on active duty. The initial manifestations of this condition never fully resolved after it arose on active duty. It remained symptomatic and developed into the chronic disability found today. According to my record review, as well as a detailed history and physical exam taken of Mr. [REDACTED] there has been continuity of symptoms from service to present. In addition, the development and progression of this condition as presented in the particular case of Mr. [REDACTED] is completely consistent with sound general medical principles as well as the consensus of expert medical opinion on the subject.

Each of the opinions below was rendered after reaching a certainty of **more likely than not - that is, the likelihood has a greater than 50 percent probability, or there is a preponderance of positive over negative evidence** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a current chronic disability of THORACOLUMBAR SPINE DEGENERATIVE ARTHRITIS.
- Mr. [REDACTED] had an in-service back illness.
- The current back condition was caused by the in-service back illness.
- The in-service back illness has persisted from the time of its first manifestation and developed into the current back condition.
- A causal nexus has been established for direct service connection of THORACOLUMBAR SPINE DEGENERATIVE ARTHRITIS.

Remark 5. Secondary service connection medical opinion with rationale

Not applicable.

Remark 6. Opinion regarding conflicting medical evidence

Not applicable.

Remark 7. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective—that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and **MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet. App. 259). In addition, I ask that clarification requests regarding my report not be directed to a C&P examiner, especially one of lesser credentials, who has no prior familiarity with Mr. [REDACTED] or this disability. Since I am readily available and responsive, such action by the VA "reasonably could be construed" as procuring evidence "for the sole purpose of denying the veteran's claim,"~~

INTERNAL VETERANS AFFAIRS USE
MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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 VA 21 2507, C&P examination request? [] Yes [X] No

How was the examination completed? (check all that apply)

- [X] In person examination
[X] Records reviewed
[] Examination via approved video telehealth
[X] Other, please specify in comments box:

Comments: Remark 1,

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 will likely provide no additional relevant evidence.
[] Review of available records in conjunction with an interview with the Veteran (without in person or 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
[X] VA claims file (hard copy paper C file)
[] VA e folder
[X] VA electronic health record
[X] Other, please identify other evidence reviewed:

Remark 2,

Evidence Comments:

Remark 2.

SECTION I - DEFINITIONS

AGGRAVATION OF PREEXISTING NONSERVICE CONNECTED DISABILITIES: A PREEXISTING INJURY OR DISEASE WILL BE CONSIDERED TO HAVE BEEN AGGRAVATED BY ACTIVE MILITARY, NAVAL, OR AIR SERVICE, WHERE THERE IS AN INCREASE IN DISABILITY DURING SUCH SERVICE, UNLESS THERE IS A SPECIFIC FINDING THAT THE INCREASE IN DISABILITY IS DUE TO THE NATURAL PROGRESS OF THE DISEASE.

AGGRAVATION OF NONSERVICE CONNECTED DISABILITIES: ANY INCREASE IN SEVERITY OF A NONSERVICE CONNECTED DISEASE OR INJURY THAT IS PROXIMATELY DUE TO OR THE RESULT OF A SERVICE CONNECTED DISEASE OR INJURY, AND NOT DUE TO THE NATURAL PROGRESS OF THE NONSERVICE CONNECTED DISEASE, WILL BE SERVICE CONNECTED.

SECTION II - RESTATEMENT OF REQUESTED OPINION

2A. INSERT REQUESTED OPINION FROM GENERAL REMARKS:

Neck condition service connection; Remark 3.

2B. INDICATE TYPE OF EXAM FOR WHICH OPINION HAS BEEN REQUESTED (e.g. skin diseases): Neck.

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- 3A. THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 3B. THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (less than 50 percent probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

3C. RATIONALE:

Remark 4.

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

- 4A. THE CLAIMED CONDITION IS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.
- 4B. THE CLAIMED CONDITION IS LESS LIKELY THAN NOT (less than 50 percent probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.

4C. RATIONALE:

Remark 5.

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

- 5A. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 5B. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS CLEARLY AND UNMISTAKABLY NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

5C. RATIONALE:

Not applicable.

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. CAN YOU DETERMINE A BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition)?

- YES NO

IF "YES" TO QUESTION 6A, ANSWER THE FOLLOWING:

I. DESCRIBE THE BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition):

Not applicable.

II. PROVIDE THE DATE AND NATURE OF THE MEDICAL EVIDENCE USED TO PROVIDE THE BASELINE:

Not applicable.

III. IS THE CURRENT SEVERITY OF THE (claimed condition/diagnosis) GREATER THAN THE BASELINE?

- YES NO

IF YES, WAS THE VETERAN'S (claimed condition/diagnosis) AT LEAST AS LIKELY AS NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY (insert "service connected condition")?

- YES (provide rationale in section 6B.)
- NO (provide rationale in section 6B.)

Remark 2. Evidence review

My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C-file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review which clearly states that private examiners are not required to review any particular set of records or even to review the C-file at all (Nieves-Rodriguez v. Peake, 22 Vet. App. 295):

...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.

Such is the case where entitlement to service connection is clearly supported in the records available for my review. This is described in more detail in the rationale section below.

Remark 3. Question requiring a medical opinion

Has a causal nexus for service connection been established for the **NECK CONDITION?**

Remark 4. Direct service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating this condition in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disability considered holistically.

The STRs clearly indicate diagnosis of CERVICAL SPINE CHRONIC STRAIN on active duty. The initial manifestations of this condition never fully resolved after it arose on active duty. It remained symptomatic and developed into the chronic disability found today. According to my record review, as well as a detailed history and physical exam taken of Mr. [REDACTED] there has been continuity of symptoms from service to present. In addition, the development and progression of this condition as presented in the particular case of Mr. [REDACTED] is completely consistent with sound general medical principles as well as the consensus of expert medical opinion on the subject.

Each of the opinions below was rendered after reaching a certainty of **more likely than not - that is, the likelihood has a greater than 50 percent probability, or there is a preponderance of positive over negative evidence** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a current chronic disability of CERVICAL SPINE CHRONIC STRAIN.
- Mr. [REDACTED] had an in-service neck illness.
- The current neck condition was caused by the in-service neck illness.
- The in-service neck illness has persisted from the time of its first manifestation and developed into the current neck condition.
- A causal nexus has been established for direct service connection of CERVICAL SPINE CHRONIC STRAIN.

Remark 5. Secondary service connection medical opinion with rationale

Not applicable.

Remark 6. Opinion regarding conflicting medical evidence

Not applicable.

Remark 7. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective - that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and **MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet. App. 259). In addition, I ask that clarification requests regarding my report not be directed to a C&P examiner, especially one of lesser credentials, who has no prior familiarity with Mr. [REDACTED] or this disability. Since I am readily available and responsive, such action by the VA "reasonably could be construed" as procuring evidence "for the sole purpose of denying the veteran's claim," also known as "developing to deny," an administrative practice that is rightly forbidden since it is~~

**INTERNAL VETERANS AFFAIRS USE
MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE**

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN <div style="background-color: black; width: 100px; height: 20px; margin-top: 5px;"></div>	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER <div style="background-color: black; width: 100px; height: 20px; margin-top: 5px;"></div>
--	---

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 VA 21 2507, 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: Remark 1.

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 will likely provide no additional relevant evidence.
- Review of available records in conjunction with an interview with the Veteran (without in person or 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
- VA claims file (hard copy paper C file)
- VA e folder
- VA electronic health record
- Other, please identify other evidence reviewed:
- No records were reviewed

Remark 2.

Evidence Comments:

Remark 2.

SECTION I - DEFINITIONS

AGGRAVATION OF PREEXISTING NONSERVICE CONNECTED DISABILITIES: A PREEXISTING INJURY OR DISEASE WILL BE CONSIDERED TO HAVE BEEN AGGRAVATED BY ACTIVE MILITARY, NAVAL, OR AIR SERVICE, WHERE THERE IS AN INCREASE IN DISABILITY DURING SUCH SERVICE, UNLESS THERE IS A SPECIFIC FINDING THAT THE INCREASE IN DISABILITY IS DUE TO THE NATURAL PROGRESS OF THE DISEASE.

AGGRAVATION OF NONSERVICE CONNECTED DISABILITIES: ANY INCREASE IN SEVERITY OF A NONSERVICE CONNECTED DISEASE OR INJURY THAT IS PROXIMATELY DUE TO OR THE RESULT OF A SERVICE CONNECTED DISEASE OR INJURY, AND NOT DUE TO THE NATURAL PROGRESS OF THE NONSERVICE CONNECTED DISEASE, WILL BE SERVICE CONNECTED.

SECTION II - RESTATEMENT OF REQUESTED OPINION

2A. INSERT REQUESTED OPINION FROM GENERAL REMARKS:

Left leg sciatic nerve condition service connection: Remark 3.

2B. INDICATE TYPE OF EXAM FOR WHICH OPINION HAS BEEN REQUESTED (e.g. skin diseases): Peripheral nerves.

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- 3A. THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 3B. THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (less than 50 percent probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

3C. RATIONALE:

Remark 4.

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

- 4A. THE CLAIMED CONDITION IS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.
- 4B. THE CLAIMED CONDITION IS LESS LIKELY THAN NOT (less than 50 percent probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.

4C. RATIONALE:

Remark 5.

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

- 5A. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 5B. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS CLEARLY AND UNMISTAKABLY NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

5C. RATIONALE:

Not applicable.

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. CAN YOU DETERMINE A BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition)?

- YES NO

IF "YES" TO QUESTION 6A, ANSWER THE FOLLOWING:

I. DESCRIBE THE BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition):

Not applicable.

II. PROVIDE THE DATE AND NATURE OF THE MEDICAL EVIDENCE USED TO PROVIDE THE BASELINE:

Not applicable.

III. IS THE CURRENT SEVERITY OF THE (claimed condition/diagnosis) GREATER THAN THE BASELINE?

- YES NO

IF YES, WAS THE VETERAN'S (claimed condition/diagnosis) AT LEAST AS LIKELY AS NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY (insert "service connected condition")?

- YES (provide rationale in section 6B.)
- NO (provide rationale in section 6B.)

Remark 2. Evidence review

~~My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C-file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review which clearly states that private examiners are not required to review any particular set of records or even to review the C-file at all (Nieves-Rodriguez v. Peake, 22 Vet. App. 295):~~

~~...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.~~

~~Such is the case where entitlement to service connection is clearly supported in the records available for my review. This is described in more detail in the rationale section below.~~

Remark 3. Question requiring a medical opinion

Has a causal nexus for service connection been established for the **LEFT LEG NERVE CONDITION?**

Remark 4. Direct service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating this condition in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disability considered holistically.

The STRs clearly indicate diagnosis of LEFT LEG SCIATIC RADICULOPATHY on active duty. The initial manifestations of this condition never fully resolved after it arose on active duty. It remained symptomatic and developed into the chronic disability found today. According to my record review, as well as a detailed history and physical exam taken of Mr. [REDACTED] there has been continuity of symptoms from service to present. In addition, the development and progression of this condition as presented in the particular case of Mr. [REDACTED] is completely consistent with sound general medical principles as well as the consensus of expert medical opinion on the subject.

Each of the opinions below was rendered after reaching a certainty of **more likely than not - that is, the likelihood has a greater than 50 percent probability, or there is a preponderance of positive over negative evidence** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a current chronic disability of LEFT LEG SCIATIC RADICULOPATHY.
- Mr. [REDACTED] had an in-service left leg nerve illness.
- The current left leg nerve condition was caused by the in-service left leg nerve illness.
- The in-service left leg nerve illness has persisted from the time of its first manifestation and developed into the current left leg nerve condition.
- A causal nexus has been established for direct service connection of LEFT LEG SCIATIC RADICULOPATHY.

Remark 5. Secondary service connection medical opinion with rationale

Not applicable.

Remark 6. Opinion regarding conflicting medical evidence

Not applicable.

Remark 7. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective - that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and **MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet. App. 259). In addition, I ask that clarification requests regarding my report not be directed to a C&P examiner, especially one of lesser credentials, who has no prior familiarity with Mr. [REDACTED] or this disability. Since I am readily available and responsive, such action by the VA "reasonably could be construed" as procuring evidence "for the sole purpose of denying the veteran's claim," also known as "developing to deny," an administrative practice that is rightly forbidden since it is~~

INTERNAL VETERANS AFFAIRS USE
MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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 VA 21 2507, C&P examination request? [] Yes [X] No

How was the examination completed? (check all that apply)

- [X] In person examination
[X] Records reviewed
[] Examination via approved video telehealth
[X] Other, please specify in comments box:

Comments: Remark 1.

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 will likely provide no additional relevant evidence.
[] Review of available records in conjunction with an interview with the Veteran (without in person or 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
[X] VA claims file (hard copy paper C file)
[] VA e folder
[X] VA electronic health record
[X] Other, please identify other evidence reviewed:

Remark 2.

Evidence Comments:

Remark 2.

SECTION I - DEFINITIONS

AGGRAVATION OF PREEXISTING NONSERVICE CONNECTED DISABILITIES: A PREEXISTING INJURY OR DISEASE WILL BE CONSIDERED TO HAVE BEEN AGGRAVATED BY ACTIVE MILITARY, NAVAL, OR AIR SERVICE, WHERE THERE IS AN INCREASE IN DISABILITY DURING SUCH SERVICE, UNLESS THERE IS A SPECIFIC FINDING THAT THE INCREASE IN DISABILITY IS DUE TO THE NATURAL PROGRESS OF THE DISEASE.

AGGRAVATION OF NONSERVICE CONNECTED DISABILITIES: ANY INCREASE IN SEVERITY OF A NONSERVICE CONNECTED DISEASE OR INJURY THAT IS PROXIMATELY DUE TO OR THE RESULT OF A SERVICE CONNECTED DISEASE OR INJURY, AND NOT DUE TO THE NATURAL PROGRESS OF THE NONSERVICE CONNECTED DISEASE, WILL BE SERVICE CONNECTED.

SECTION II - RESTATEMENT OF REQUESTED OPINION

2A. INSERT REQUESTED OPINION FROM GENERAL REMARKS:

Right arm ulnar nerve condition service connection: Remark 3.

2B. INDICATE TYPE OF EXAM FOR WHICH OPINION HAS BEEN REQUESTED (e.g. skin diseases): Peripheral nerves.

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- 3A. THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 3B. THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (less than 50 percent probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

3C. RATIONALE:

Remark 4.

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

- 4A. THE CLAIMED CONDITION IS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.
- 4B. THE CLAIMED CONDITION IS LESS LIKELY THAN NOT (less than 50 percent probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.

4C. RATIONALE:

Remark 5.

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

- 5A. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 5B. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS CLEARLY AND UNMISTAKABLY NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

5C. RATIONALE:

Not applicable.

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. CAN YOU DETERMINE A BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition)?

- YES NO

IF "YES" TO QUESTION 6A, ANSWER THE FOLLOWING:

I. DESCRIBE THE BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition):

Not applicable.

II. PROVIDE THE DATE AND NATURE OF THE MEDICAL EVIDENCE USED TO PROVIDE THE BASELINE:

Not applicable.

III. IS THE CURRENT SEVERITY OF THE (claimed condition/diagnosis) GREATER THAN THE BASELINE?

- YES NO

IF YES, WAS THE VETERAN'S (claimed condition/diagnosis) AT LEAST AS LIKELY AS NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY (insert "service connected condition")?

- YES (provide rationale in section 6B.)
- NO (provide rationale in section 6B.)

Remark 2. Evidence review

~~My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C-file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review which clearly states that private examiners are not required to review any particular set of records or even to review the C-file at all (Nieves-Rodriguez v. Peake, 22 Vet. App. 295):~~

~~...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.~~

~~Such is the case where entitlement to service connection is clearly supported in the records available for my review. This is described in more detail in the rationale section below.~~

Remark 3. Question requiring a medical opinion

Has a causal nexus for service connection been established for the **RIGHT ARM NERVE CONDITION?**

Remark 4. Direct service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating this condition in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disability considered holistically.

The STRs clearly indicate diagnosis of RIGHT ARM ULNAR NEUROPATHY on active duty. The initial manifestations of this condition never fully resolved after it arose on active duty. It remained symptomatic and developed into the chronic disability found today. According to my record review, as well as a detailed history and physical exam taken of Mr. [REDACTED] there has been continuity of symptoms from service to present. In addition, the development and progression of this condition as presented in the particular case of Mr. [REDACTED] is completely consistent with sound general medical principles as well as the consensus of expert medical opinion on the subject.

Each of the opinions below was rendered after reaching a certainty of **more likely than not - that is, the likelihood has a greater than 50 percent probability, or there is a preponderance of positive over negative evidence** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a current chronic disability of RIGHT ARM ULNAR NEUROPATHY.
- Mr. [REDACTED] had an in-service right arm nerve illness.
- The current right arm nerve condition was caused by the in-service right arm nerve illness.
- The in-service right arm nerve illness has persisted from the time of its first manifestation and developed into the current right arm nerve condition.
- A causal nexus has been established for direct service connection of RIGHT ARM ULNAR NEUROPATHY.

Remark 5. Secondary service connection medical opinion with rationale

Not applicable.

Remark 6. Opinion regarding conflicting medical evidence

Not applicable.

Remark 7. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective - that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and **MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet. App. 259). In addition, I ask that clarification requests regarding my report not be directed to a C&P examiner, especially one of lesser credentials, who has no prior familiarity with Mr. [REDACTED] or this disability. Since I am readily available and responsive, such action by the VA "reasonably could be construed" as procuring evidence "for the sole purpose of denying the veteran's claim," also known as "developing to deny," an administrative practice that is rightly forbidden since it is~~

INTERNAL VETERANS AFFAIRS USE
MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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 VA 21 2507, C&P examination request? [] Yes [X] No

How was the examination completed? (check all that apply)

- [X] In person examination
[X] Records reviewed
[] Examination via approved video telehealth
[X] Other, please specify in comments box:

Comments: Remark 1,

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 will likely provide no additional relevant evidence.
[] Review of available records in conjunction with an interview with the Veteran (without in person or 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
[X] VA claims file (hard copy paper C file)
[] VA e folder
[X] VA electronic health record
[X] Other, please identify other evidence reviewed:

Remark 2,

Evidence Comments:

Remark 2.

SECTION I - DEFINITIONS

AGGRAVATION OF PREEXISTING NONSERVICE CONNECTED DISABILITIES: A PREEXISTING INJURY OR DISEASE WILL BE CONSIDERED TO HAVE BEEN AGGRAVATED BY ACTIVE MILITARY, NAVAL, OR AIR SERVICE, WHERE THERE IS AN INCREASE IN DISABILITY DURING SUCH SERVICE, UNLESS THERE IS A SPECIFIC FINDING THAT THE INCREASE IN DISABILITY IS DUE TO THE NATURAL PROGRESS OF THE DISEASE.

AGGRAVATION OF NONSERVICE CONNECTED DISABILITIES: ANY INCREASE IN SEVERITY OF A NONSERVICE CONNECTED DISEASE OR INJURY THAT IS PROXIMATELY DUE TO OR THE RESULT OF A SERVICE CONNECTED DISEASE OR INJURY, AND NOT DUE TO THE NATURAL PROGRESS OF THE NONSERVICE CONNECTED DISEASE, WILL BE SERVICE CONNECTED.

SECTION II - RESTATEMENT OF REQUESTED OPINION

2A. INSERT REQUESTED OPINION FROM GENERAL REMARKS:

Foot condition service connection; Remark 3.

2B. INDICATE TYPE OF EXAM FOR WHICH OPINION HAS BEEN REQUESTED (e.g. skin diseases): Foot.

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- 3A. THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 3B. THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (less than 50 percent probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

3C. RATIONALE:

Remark 4.

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

- 4A. THE CLAIMED CONDITION IS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.
- 4B. THE CLAIMED CONDITION IS LESS LIKELY THAN NOT (less than 50 percent probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.

4C. RATIONALE:

Remark 5.

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

- 5A. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 5B. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS CLEARLY AND UNMISTAKABLY NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

5C. RATIONALE:

Not applicable.

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. CAN YOU DETERMINE A BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition)?

- YES NO

IF "YES" TO QUESTION 6A, ANSWER THE FOLLOWING:

I. DESCRIBE THE BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition):

Not applicable.

II. PROVIDE THE DATE AND NATURE OF THE MEDICAL EVIDENCE USED TO PROVIDE THE BASELINE:

Not applicable.

III. IS THE CURRENT SEVERITY OF THE (claimed condition/diagnosis) GREATER THAN THE BASELINE?

- YES NO

IF YES, WAS THE VETERAN'S (claimed condition/diagnosis) AT LEAST AS LIKELY AS NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY (insert "service connected condition")?

- YES (provide rationale in section 6B.)
- NO (provide rationale in section 6B.)

Remark 2. Evidence review

~~My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C-file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review which clearly states that private examiners are not required to review any particular set of records or even to review the C-file at all (Nieves-Rodriguez v. Peake, 22 Vet. App. 295):~~

~~...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.~~

~~Such is the case where entitlement to service connection is clearly supported in the records available for my review. This is described in more detail in the rationale section below.~~

Remark 3. Question requiring a medical opinion

Has a causal nexus for service connection been established for the **BILATERAL FOOT CONDITION?**

Remark 4. Direct service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating this condition in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disability considered holistically.

The STRs clearly indicate diagnosis of BILATERAL FOOT PLANTAR FASCIITIS on active duty. The initial manifestations of this condition never fully resolved after it arose on active duty. It remained symptomatic and developed into the chronic disability found today. According to my record review, as well as a detailed history and physical exam taken of Mr. [REDACTED] there has been continuity of symptoms from service to present. In addition, the development and progression of this condition as presented in the particular case of Mr. [REDACTED] is completely consistent with sound general medical principles as well as the consensus of expert medical opinion on the subject.

Each of the opinions below was rendered after reaching a certainty of **more likely than not - that is, the likelihood has a greater than 50 percent probability, or there is a preponderance of positive over negative evidence** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a current chronic disability of BILATERAL FOOT PLANTAR FASCIITIS.
- Mr. [REDACTED] had an in-service bilateral foot illness.
- The current bilateral foot condition was caused by the in-service bilateral foot illness.
- The in-service bilateral foot illness has persisted from the time of its first manifestation and developed into the current bilateral foot condition.
- A causal nexus has been established for direct service connection of BILATERAL FOOT PLANTAR FASCIITIS.

Remark 5. Secondary service connection medical opinion with rationale

Not applicable.

Remark 6. Opinion regarding conflicting medical evidence

Not applicable.

Remark 7. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective - that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and **MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet. App. 259). In addition, I ask that clarification requests regarding my report not be directed to a C&P examiner, especially one of lesser credentials, who has no prior familiarity with Mr. [REDACTED] or this disability. Since I am readily available and responsive, such action by the VA "reasonably could be construed" as procuring evidence "for the sole purpose of denying the veteran's claim," also known as "developing to deny," an administrative practice that is rightly forbidden since it is~~

**INTERNAL VETERANS AFFAIRS USE
MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE**

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN <div style="background-color: black; width: 100%; height: 1.2em; margin-top: 5px;"></div>	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER <div style="background-color: black; width: 100%; height: 1.2em; margin-top: 5px;"></div>
--	---

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 VA 21 2507, 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: Remark 1,

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 will likely provide no additional relevant evidence.
- Review of available records in conjunction with an interview with the Veteran (without in person or 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
- VA claims file (hard copy paper C file)
- VA e folder
- VA electronic health record
- Other, please identify other evidence reviewed:
- No records were reviewed

Remark 2,

Evidence Comments:

Remark 2.

SECTION I - DEFINITIONS

AGGRAVATION OF PREEXISTING NONSERVICE CONNECTED DISABILITIES: A PREEXISTING INJURY OR DISEASE WILL BE CONSIDERED TO HAVE BEEN AGGRAVATED BY ACTIVE MILITARY, NAVAL, OR AIR SERVICE, WHERE THERE IS AN INCREASE IN DISABILITY DURING SUCH SERVICE, UNLESS THERE IS A SPECIFIC FINDING THAT THE INCREASE IN DISABILITY IS DUE TO THE NATURAL PROGRESS OF THE DISEASE.

AGGRAVATION OF NONSERVICE CONNECTED DISABILITIES: ANY INCREASE IN SEVERITY OF A NONSERVICE CONNECTED DISEASE OR INJURY THAT IS PROXIMATELY DUE TO OR THE RESULT OF A SERVICE CONNECTED DISEASE OR INJURY, AND NOT DUE TO THE NATURAL PROGRESS OF THE NONSERVICE CONNECTED DISEASE, WILL BE SERVICE CONNECTED.

SECTION II - RESTATEMENT OF REQUESTED OPINION

2A. INSERT REQUESTED OPINION FROM GENERAL REMARKS:

Right elbow condition service connection: Remark 3.

2B. INDICATE TYPE OF EXAM FOR WHICH OPINION HAS BEEN REQUESTED (e.g. skin diseases): Elbow.

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- 3A. THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 3B. THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (less than 50 percent probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

3C. RATIONALE:

Remark 4.

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

- 4A. THE CLAIMED CONDITION IS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.
- 4B. THE CLAIMED CONDITION IS LESS LIKELY THAN NOT (less than 50 percent probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.

4C. RATIONALE:

Remark 5.

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

- 5A. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 5B. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS CLEARLY AND UNMISTAKABLY NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

5C. RATIONALE:

Not applicable.

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. CAN YOU DETERMINE A BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition)?

- YES NO

IF "YES" TO QUESTION 6A, ANSWER THE FOLLOWING:

I. DESCRIBE THE BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition):

Not applicable.

II. PROVIDE THE DATE AND NATURE OF THE MEDICAL EVIDENCE USED TO PROVIDE THE BASELINE:

Not applicable.

III. IS THE CURRENT SEVERITY OF THE (claimed condition/diagnosis) GREATER THAN THE BASELINE?

- YES NO

IF YES, WAS THE VETERAN'S (claimed condition/diagnosis) AT LEAST AS LIKELY AS NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY (insert "service connected condition")?

- YES (provide rationale in section 6B.)
- NO (provide rationale in section 6B.)

Remark 2. Evidence review

My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C-file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review which clearly states that private examiners are not required to review any particular set of records or even to review the C-file at all (Nieves-Rodriguez v. Peake, 22 Vet. App. 295):

...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.

Such is the case where entitlement to service connection is clearly supported in the records available for my review. This is described in more detail in the rationale section below.

Remark 3. Question requiring a medical opinion

Has a causal nexus for service connection been established for the **RIGHT ELBOW CONDITION?**

Remark 4. Direct service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating this condition in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disability considered holistically.

The STRs clearly indicate diagnosis of RIGHT ELBOW LATERAL EPICONDYLITIS AND BICIPITAL TENDONITIS on active duty. The initial manifestations of this condition never fully resolved after it arose on active duty. It remained symptomatic and developed into the chronic disability found today. According to my record review, as well as a detailed history and physical exam taken of Mr. [REDACTED] there has been continuity of symptoms from service to present. In addition, the development and progression of this condition as presented in the particular case of Mr. [REDACTED] is completely consistent with sound general medical principles as well as the consensus of expert medical opinion on the subject.

Each of the opinions below was rendered after reaching a certainty of **more likely than not - that is, the likelihood has a greater than 50 percent probability, or there is a preponderance of positive over negative evidence** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a current chronic disability of RIGHT ELBOW LATERAL EPICONDYLITIS AND BICIPITAL TENDONITIS.
- Mr. [REDACTED] had an in-service right elbow illness.
- The current right elbow condition was caused by the in-service right elbow illness.
- The in-service right elbow illness has persisted from the time of its first manifestation and developed into the current right elbow condition.
- A causal nexus has been established for direct service connection of RIGHT ELBOW LATERAL EPICONDYLITIS AND BICIPITAL TENDONITIS.

Remark 5. Secondary service connection medical opinion with rationale

Not applicable.

Remark 6. Opinion regarding conflicting medical evidence

Not applicable.

Remark 7. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective—that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and **MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet. App. 259). In addition, I ask that clarification requests regarding my report not be directed to a C&P examiner, especially one of lesser credentials, who has no prior familiarity with Mr. [REDACTED] or this disability. Since I am readily available and responsive, such action by the VA "reasonably could be construed" as procuring evidence "for the sole purpose of denying the veteran's claim,"~~

INTERNAL VETERANS AFFAIRS USE
MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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 VA 21 2507, C&P examination request? [] Yes [X] No

How was the examination completed? (check all that apply)

- [X] In person examination
[X] Records reviewed
[] Examination via approved video telehealth
[X] Other, please specify in comments box:

Comments: Remark 1,

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 will likely provide no additional relevant evidence.
[] Review of available records in conjunction with an interview with the Veteran (without in person or 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
[X] VA claims file (hard copy paper C file)
[] VA e folder
[X] VA electronic health record
[X] Other, please identify other evidence reviewed:

Remark 2,

Evidence Comments:

Remark 2,

SECTION I - DEFINITIONS

AGGRAVATION OF PREEXISTING NONSERVICE CONNECTED DISABILITIES: A PREEXISTING INJURY OR DISEASE WILL BE CONSIDERED TO HAVE BEEN AGGRAVATED BY ACTIVE MILITARY, NAVAL, OR AIR SERVICE, WHERE THERE IS AN INCREASE IN DISABILITY DURING SUCH SERVICE, UNLESS THERE IS A SPECIFIC FINDING THAT THE INCREASE IN DISABILITY IS DUE TO THE NATURAL PROGRESS OF THE DISEASE.

AGGRAVATION OF NONSERVICE CONNECTED DISABILITIES: ANY INCREASE IN SEVERITY OF A NONSERVICE CONNECTED DISEASE OR INJURY THAT IS PROXIMATELY DUE TO OR THE RESULT OF A SERVICE CONNECTED DISEASE OR INJURY, AND NOT DUE TO THE NATURAL PROGRESS OF THE NONSERVICE CONNECTED DISEASE, WILL BE SERVICE CONNECTED.

SECTION II - RESTATEMENT OF REQUESTED OPINION

2A. INSERT REQUESTED OPINION FROM GENERAL REMARKS:

Right shoulder condition service connection; Remark 3.

2B. INDICATE TYPE OF EXAM FOR WHICH OPINION HAS BEEN REQUESTED (e.g. skin diseases): Shoulder.

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- 3A. THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 3B. THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (less than 50 percent probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

3C. RATIONALE:

Remark 4.

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

- 4A. THE CLAIMED CONDITION IS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.
- 4B. THE CLAIMED CONDITION IS LESS LIKELY THAN NOT (less than 50 percent probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.

4C. RATIONALE:

Remark 5.

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

- 5A. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 5B. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS CLEARLY AND UNMISTAKABLY NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

5C. RATIONALE:

Not applicable.

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. CAN YOU DETERMINE A BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition)?

- YES NO

IF "YES" TO QUESTION 6A, ANSWER THE FOLLOWING:

I. DESCRIBE THE BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition):

Not applicable.

II. PROVIDE THE DATE AND NATURE OF THE MEDICAL EVIDENCE USED TO PROVIDE THE BASELINE:

Not applicable.

III. IS THE CURRENT SEVERITY OF THE (claimed condition/diagnosis) GREATER THAN THE BASELINE?

- YES NO

IF YES, WAS THE VETERAN'S (claimed condition/diagnosis) AT LEAST AS LIKELY AS NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY (insert "service connected condition")?

- YES (provide rationale in section 6B.)
- NO (provide rationale in section 6B.)

Remark 2. Evidence review

My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C-file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review which clearly states that private examiners are not required to review any particular set of records or even to review the C-file at all (Nieves-Rodriguez v. Peake, 22 Vet. App. 295):

...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.

Such is the case where entitlement to service connection is clearly supported in the records available for my review. This is described in more detail in the rationale section below.

Remark 3. Question requiring a medical opinion

Has a causal nexus for service connection been established for the **RIGHT SHOULDER CONDITION?**

Remark 4. Direct service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating this condition in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disability considered holistically.

The STRs clearly indicate diagnosis of RIGHT SHOULDER OSTEOARTHRITIS WITH ROTATOR CUFF TEAR on active duty. The initial manifestations of this condition never fully resolved after it arose on active duty. It remained symptomatic and developed into the chronic disability found today. According to my record review, as well as a detailed history and physical exam taken of Mr. [REDACTED] there has been continuity of symptoms from service to present. In addition, the development and progression of this condition as presented in the particular case of Mr. [REDACTED] is completely consistent with sound general medical principles as well as the consensus of expert medical opinion on the subject.

Each of the opinions below was rendered after reaching a certainty of **more likely than not - that is, the likelihood has a greater than 50 percent probability, or there is a preponderance of positive over negative evidence** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a current chronic disability of RIGHT SHOULDER OSTEOARTHRITIS WITH ROTATOR CUFF TEAR.
- Mr. [REDACTED] had an in-service right shoulder illness.
- The current right shoulder condition was caused by the in-service right shoulder illness.
- The in-service right shoulder illness has persisted from the time of its first manifestation and developed into the current right shoulder condition.
- A causal nexus has been established for direct service connection of RIGHT SHOULDER OSTEOARTHRITIS WITH ROTATOR CUFF TEAR.

Remark 5. Secondary service connection medical opinion with rationale

Not applicable.

Remark 6. Opinion regarding conflicting medical evidence

Not applicable.

Remark 7. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective—that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and **MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet. App. 259). In addition, I ask that clarification requests regarding my report not be directed to a C&P examiner, especially one of lesser credentials, who has no prior familiarity with Mr. [REDACTED] or this disability. Since I am readily available and responsive, such action by the VA "reasonably could be construed" as procuring evidence "for the sole purpose of denying the veteran's claim,"~~

**INTERNAL VETERANS AFFAIRS USE
MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE**

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN <div style="background-color: black; width: 100%; height: 1.2em; margin-top: 5px;"></div>	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER <div style="background-color: black; width: 100%; height: 1.2em; margin-top: 5px;"></div>
--	---

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 VA 21 2507, 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: Remark 1,

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 will likely provide no additional relevant evidence.
- Review of available records in conjunction with an interview with the Veteran (without in person or 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
- VA claims file (hard copy paper C file)
- VA e folder
- VA electronic health record
- Other, please identify other evidence reviewed:
- No records were reviewed

Remark 2,

Evidence Comments:

Remark 2.

SECTION I - DEFINITIONS

AGGRAVATION OF PREEXISTING NONSERVICE CONNECTED DISABILITIES: A PREEXISTING INJURY OR DISEASE WILL BE CONSIDERED TO HAVE BEEN AGGRAVATED BY ACTIVE MILITARY, NAVAL, OR AIR SERVICE, WHERE THERE IS AN INCREASE IN DISABILITY DURING SUCH SERVICE, UNLESS THERE IS A SPECIFIC FINDING THAT THE INCREASE IN DISABILITY IS DUE TO THE NATURAL PROGRESS OF THE DISEASE.

AGGRAVATION OF NONSERVICE CONNECTED DISABILITIES: ANY INCREASE IN SEVERITY OF A NONSERVICE CONNECTED DISEASE OR INJURY THAT IS PROXIMATELY DUE TO OR THE RESULT OF A SERVICE CONNECTED DISEASE OR INJURY, AND NOT DUE TO THE NATURAL PROGRESS OF THE NONSERVICE CONNECTED DISEASE, WILL BE SERVICE CONNECTED.

SECTION II - RESTATEMENT OF REQUESTED OPINION

2A. INSERT REQUESTED OPINION FROM GENERAL REMARKS:

Left shoulder condition service connection: Remark 3.

2B. INDICATE TYPE OF EXAM FOR WHICH OPINION HAS BEEN REQUESTED (e.g. skin diseases): Shoulder.

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- 3A. THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 3B. THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (less than 50 percent probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

3C. RATIONALE:

Remark 4.

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

- 4A. THE CLAIMED CONDITION IS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.
- 4B. THE CLAIMED CONDITION IS LESS LIKELY THAN NOT (less than 50 percent probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.

4C. RATIONALE:

Remark 5.

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

- 5A. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 5B. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS CLEARLY AND UNMISTAKABLY NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

5C. RATIONALE:

Not applicable.

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. CAN YOU DETERMINE A BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition)?

- YES NO

IF "YES" TO QUESTION 6A, ANSWER THE FOLLOWING:

I. DESCRIBE THE BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition):

Not applicable.

II. PROVIDE THE DATE AND NATURE OF THE MEDICAL EVIDENCE USED TO PROVIDE THE BASELINE:

Not applicable.

III. IS THE CURRENT SEVERITY OF THE (claimed condition/diagnosis) GREATER THAN THE BASELINE?

- YES NO

IF YES, WAS THE VETERAN'S (claimed condition/diagnosis) AT LEAST AS LIKELY AS NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY (insert "service connected condition")?

- YES (provide rationale in section 6B.)
- NO (provide rationale in section 6B.)

Remark 2. Evidence review

~~My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C-file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review which clearly states that private examiners are not required to review any particular set of records or even to review the C-file at all (Nieves-Rodriguez v. Peake, 22 Vet. App. 295):~~

~~...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.~~

~~Such is the case where entitlement to service connection is clearly supported in the records available for my review. This is described in more detail in the rationale section below.~~

Remark 3. Question requiring a medical opinion

Has a causal nexus for service connection been established for the **LEFT SHOULDER CONDITION?**

Remark 4. Direct service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating this condition in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disability considered holistically.

The STRs clearly indicate diagnosis of LEFT SHOULDER OSTEOARTHRITIS on active duty. The initial manifestations of this condition never fully resolved after it arose on active duty. It remained symptomatic and developed into the chronic disability found today. According to my record review, as well as a detailed history and physical exam taken of Mr. [REDACTED] there has been continuity of symptoms from service to present. In addition, the development and progression of this condition as presented in the particular case of Mr. [REDACTED] is completely consistent with sound general medical principles as well as the consensus of expert medical opinion on the subject.

Each of the opinions below was rendered after reaching a certainty of **more likely than not - that is, the likelihood has a greater than 50 percent probability, or there is a preponderance of positive over negative evidence** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a current chronic disability of LEFT SHOULDER OSTEOARTHRITIS.
- Mr. [REDACTED] had an in-service left shoulder illness.
- The current left shoulder condition was caused by the in-service left shoulder illness.
- The in-service left shoulder illness has persisted from the time of its first manifestation and developed into the current left shoulder condition.
- A causal nexus has been established for direct service connection of LEFT SHOULDER OSTEOARTHRITIS.

Remark 5. Secondary service connection medical opinion with rationale

Not applicable.

Remark 6. Opinion regarding conflicting medical evidence

Not applicable.

Remark 7. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective - that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and **MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet. App. 259). In addition, I ask that clarification requests regarding my report not be directed to a C&P examiner, especially one of lesser credentials, who has no prior familiarity with Mr. [REDACTED] or this disability. Since I am readily available and responsive, such action by the VA "reasonably could be construed" as procuring evidence "for the sole purpose of denying the veteran's claim," also known as "developing to deny," an administrative practice that is rightly forbidden since it is~~

**INTERNAL VETERANS AFFAIRS USE
MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE**

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

[REDACTED]

[REDACTED]

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 VA 21 2507, 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: Remark 1,

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 will likely provide no additional relevant evidence.
- Review of available records in conjunction with an interview with the Veteran (without in person or 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
- VA claims file (hard copy paper C file)
- VA e folder
- VA electronic health record
- Other, please identify other evidence reviewed:
- No records were reviewed

Remark 2,

Evidence Comments:

Remark 2.

SECTION I - DEFINITIONS

AGGRAVATION OF PREEXISTING NONSERVICE CONNECTED DISABILITIES: A PREEXISTING INJURY OR DISEASE WILL BE CONSIDERED TO HAVE BEEN AGGRAVATED BY ACTIVE MILITARY, NAVAL, OR AIR SERVICE, WHERE THERE IS AN INCREASE IN DISABILITY DURING SUCH SERVICE, UNLESS THERE IS A SPECIFIC FINDING THAT THE INCREASE IN DISABILITY IS DUE TO THE NATURAL PROGRESS OF THE DISEASE.

AGGRAVATION OF NONSERVICE CONNECTED DISABILITIES: ANY INCREASE IN SEVERITY OF A NONSERVICE CONNECTED DISEASE OR INJURY THAT IS PROXIMATELY DUE TO OR THE RESULT OF A SERVICE CONNECTED DISEASE OR INJURY, AND NOT DUE TO THE NATURAL PROGRESS OF THE NONSERVICE CONNECTED DISEASE, WILL BE SERVICE CONNECTED.

SECTION II - RESTATEMENT OF REQUESTED OPINION

2A. INSERT REQUESTED OPINION FROM GENERAL REMARKS:

Right hip condition service connection; Remark 3.

2B. INDICATE TYPE OF EXAM FOR WHICH OPINION HAS BEEN REQUESTED (e.g. skin diseases): Hip.

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- 3A. THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 3B. THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (less than 50 percent probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

3C. RATIONALE:

Remark 4.

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

- 4A. THE CLAIMED CONDITION IS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.
- 4B. THE CLAIMED CONDITION IS LESS LIKELY THAN NOT (less than 50 percent probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.

4C. RATIONALE:

Remark 5.

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

- 5A. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 5B. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS CLEARLY AND UNMISTAKABLY NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

5C. RATIONALE:

Not applicable.

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. CAN YOU DETERMINE A BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition)?

- YES NO

IF "YES" TO QUESTION 6A, ANSWER THE FOLLOWING:

I. DESCRIBE THE BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition):

Not applicable.

II. PROVIDE THE DATE AND NATURE OF THE MEDICAL EVIDENCE USED TO PROVIDE THE BASELINE:

Not applicable.

III. IS THE CURRENT SEVERITY OF THE (claimed condition/diagnosis) GREATER THAN THE BASELINE?

- YES NO

IF YES, WAS THE VETERAN'S (claimed condition/diagnosis) AT LEAST AS LIKELY AS NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY (insert "service connected condition")?

- YES (provide rationale in section 6B.)
- NO (provide rationale in section 6B.)

Remark 2. Evidence review

My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C-file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review which clearly states that private examiners are not required to review any particular set of records or even to review the C-file at all (Nieves-Rodriguez v. Peake, 22 Vet. App. 295):

...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.

Such is the case where entitlement to service connection is clearly supported in the records available for my review. This is described in more detail in the rationale section below.

Remark 3. Question requiring a medical opinion

Has a causal nexus for service connection been established for the **RIGHT HIP CONDITION?**

Remark 4. Direct service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating this condition in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disability considered holistically.

The STRs clearly indicate diagnosis of RIGHT HIP OSTEOARTHRITIS on active duty. The initial manifestations of this condition never fully resolved after it arose on active duty. It remained symptomatic and developed into the chronic disability found today. According to my record review, as well as a detailed history and physical exam taken of Mr. [REDACTED] there has been continuity of symptoms from service to present. In addition, the development and progression of this condition as presented in the particular case of Mr. [REDACTED] is completely consistent with sound general medical principles as well as the consensus of expert medical opinion on the subject.

Each of the opinions below was rendered after reaching a certainty of **more likely than not - that is, the likelihood has a greater than 50 percent probability, or there is a preponderance of positive over negative evidence** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a current chronic disability of RIGHT HIP OSTEOARTHRITIS.
- Mr. [REDACTED] had an in-service right hip illness.
- The current right hip condition was caused by the in-service right hip illness.
- The in-service right hip illness has persisted from the time of its first manifestation and developed into the current right hip condition.
- A causal nexus has been established for direct service connection of RIGHT HIP OSTEOARTHRITIS.

Remark 5. Secondary service connection medical opinion with rationale

Not applicable.

Remark 6. Opinion regarding conflicting medical evidence

Not applicable.

Remark 7. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective - that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and **MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet. App. 259). In addition, I ask that clarification requests regarding my report not be directed to a C&P examiner, especially one of lesser credentials, who has no prior familiarity with Mr. [REDACTED] or this disability. Since I am readily available and responsive, such action by the VA "reasonably could be construed" as procuring evidence "for the sole purpose of denying the veteran's claim," also known as "developing to deny," an administrative practice that is rightly forbidden since it is~~

**INTERNAL VETERANS AFFAIRS USE
MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE**

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

[REDACTED]

[REDACTED]

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 VA 21 2507, 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: Remark 1,

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 will likely provide no additional relevant evidence.
- Review of available records in conjunction with an interview with the Veteran (without in person or 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
- VA claims file (hard copy paper C file)
- VA e folder
- VA electronic health record
- Other, please identify other evidence reviewed:

No records were reviewed

Remark 2,

Evidence Comments:

Remark 2.

SECTION I - DEFINITIONS

AGGRAVATION OF PREEXISTING NONSERVICE CONNECTED DISABILITIES: A PREEXISTING INJURY OR DISEASE WILL BE CONSIDERED TO HAVE BEEN AGGRAVATED BY ACTIVE MILITARY, NAVAL, OR AIR SERVICE, WHERE THERE IS AN INCREASE IN DISABILITY DURING SUCH SERVICE, UNLESS THERE IS A SPECIFIC FINDING THAT THE INCREASE IN DISABILITY IS DUE TO THE NATURAL PROGRESS OF THE DISEASE.

AGGRAVATION OF NONSERVICE CONNECTED DISABILITIES: ANY INCREASE IN SEVERITY OF A NONSERVICE CONNECTED DISEASE OR INJURY THAT IS PROXIMATELY DUE TO OR THE RESULT OF A SERVICE CONNECTED DISEASE OR INJURY, AND NOT DUE TO THE NATURAL PROGRESS OF THE NONSERVICE CONNECTED DISEASE, WILL BE SERVICE CONNECTED.

SECTION II - RESTATEMENT OF REQUESTED OPINION

2A. INSERT REQUESTED OPINION FROM GENERAL REMARKS:

Left hip condition service connection; Remark 3.

2B. INDICATE TYPE OF EXAM FOR WHICH OPINION HAS BEEN REQUESTED (e.g. skin diseases): Hip.

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- 3A. THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 3B. THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (less than 50 percent probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

3C. RATIONALE:

Remark 4.

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

- 4A. THE CLAIMED CONDITION IS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.
- 4B. THE CLAIMED CONDITION IS LESS LIKELY THAN NOT (less than 50 percent probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.

4C. RATIONALE:

Remark 5.

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

- 5A. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 5B. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS CLEARLY AND UNMISTAKABLY NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

5C. RATIONALE:

Not applicable.

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. CAN YOU DETERMINE A BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition)?

- YES NO

IF "YES" TO QUESTION 6A, ANSWER THE FOLLOWING:

I. DESCRIBE THE BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition):

Not applicable.

II. PROVIDE THE DATE AND NATURE OF THE MEDICAL EVIDENCE USED TO PROVIDE THE BASELINE:

Not applicable.

III. IS THE CURRENT SEVERITY OF THE (claimed condition/diagnosis) GREATER THAN THE BASELINE?

- YES NO

IF YES, WAS THE VETERAN'S (claimed condition/diagnosis) AT LEAST AS LIKELY AS NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY (insert "service connected condition")?

- YES (provide rationale in section 6B.)
- NO (provide rationale in section 6B.)

Remark 2. Evidence review

~~My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C-file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review which clearly states that private examiners are not required to review any particular set of records or even to review the C-file at all (Nieves-Rodriguez v. Peake, 22 Vet. App. 295):~~

~~...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.~~

~~Such is the case where entitlement to service connection is clearly supported in the records available for my review. This is described in more detail in the rationale section below.~~

Remark 3. Question requiring a medical opinion

Has a causal nexus for service connection been established for the **LEFT HIP CONDITION?**

Remark 4. Direct service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating this condition in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disability considered holistically.

The STRs clearly indicate diagnosis of LEFT HIP OSTEOARTHRITIS on active duty. The initial manifestations of this condition never fully resolved after it arose on active duty. It remained symptomatic and developed into the chronic disability found today. According to my record review, as well as a detailed history and physical exam taken of Mr. [REDACTED] there has been continuity of symptoms from service to present. In addition, the development and progression of this condition as presented in the particular case of Mr. [REDACTED] is completely consistent with sound general medical principles as well as the consensus of expert medical opinion on the subject.

Each of the opinions below was rendered after reaching a certainty of **more likely than not - that is, the likelihood has a greater than 50 percent probability, or there is a preponderance of positive over negative evidence** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a current chronic disability of LEFT HIP OSTEOARTHRITIS.
- Mr. [REDACTED] had an in-service left hip illness.
- The current left hip condition was caused by the in-service left hip illness.
- The in-service left hip illness has persisted from the time of its first manifestation and developed into the current left hip condition.
- A causal nexus has been established for direct service connection of LEFT HIP OSTEOARTHRITIS.

Remark 5. Secondary service connection medical opinion with rationale

Not applicable.

Remark 6. Opinion regarding conflicting medical evidence

Not applicable.

Remark 7. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective - that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and **MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet. App. 259). In addition, I ask that clarification requests regarding my report not be directed to a C&P examiner, especially one of lesser credentials, who has no prior familiarity with Mr. [REDACTED] or this disability. Since I am readily available and responsive, such action by the VA "reasonably could be construed" as procuring evidence "for the sole purpose of denying the veteran's claim," also known as "developing to deny," an administrative practice that is rightly forbidden since it is~~

**INTERNAL VETERANS AFFAIRS USE
MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE**

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

[REDACTED]

[REDACTED]

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 VA 21 2507, 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: Remark 1,

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 will likely provide no additional relevant evidence.
- Review of available records in conjunction with an interview with the Veteran (without in person or 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
- VA claims file (hard copy paper C file)
- VA e folder
- VA electronic health record
- Other, please identify other evidence reviewed:
- No records were reviewed

Remark 2,

Evidence Comments:

Remark 2.

SECTION I - DEFINITIONS

AGGRAVATION OF PREEXISTING NONSERVICE CONNECTED DISABILITIES: A PREEXISTING INJURY OR DISEASE WILL BE CONSIDERED TO HAVE BEEN AGGRAVATED BY ACTIVE MILITARY, NAVAL, OR AIR SERVICE, WHERE THERE IS AN INCREASE IN DISABILITY DURING SUCH SERVICE, UNLESS THERE IS A SPECIFIC FINDING THAT THE INCREASE IN DISABILITY IS DUE TO THE NATURAL PROGRESS OF THE DISEASE.

AGGRAVATION OF NONSERVICE CONNECTED DISABILITIES: ANY INCREASE IN SEVERITY OF A NONSERVICE CONNECTED DISEASE OR INJURY THAT IS PROXIMATELY DUE TO OR THE RESULT OF A SERVICE CONNECTED DISEASE OR INJURY, AND NOT DUE TO THE NATURAL PROGRESS OF THE NONSERVICE CONNECTED DISEASE, WILL BE SERVICE CONNECTED.

SECTION II - RESTATEMENT OF REQUESTED OPINION

2A. INSERT REQUESTED OPINION FROM GENERAL REMARKS:

Right knee condition service connection; Remark 3.

2B. INDICATE TYPE OF EXAM FOR WHICH OPINION HAS BEEN REQUESTED (e.g. skin diseases): Knee.

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- 3A. THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 3B. THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (less than 50 percent probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

3C. RATIONALE:

Remark 4.

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

- 4A. THE CLAIMED CONDITION IS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.
- 4B. THE CLAIMED CONDITION IS LESS LIKELY THAN NOT (less than 50 percent probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.

4C. RATIONALE:

Remark 5.

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

- 5A. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 5B. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS CLEARLY AND UNMISTAKABLY NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

5C. RATIONALE:

Not applicable.

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. CAN YOU DETERMINE A BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition)?

- YES NO

IF "YES" TO QUESTION 6A, ANSWER THE FOLLOWING:

I. DESCRIBE THE BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition):

Not applicable.

II. PROVIDE THE DATE AND NATURE OF THE MEDICAL EVIDENCE USED TO PROVIDE THE BASELINE:

Not applicable.

III. IS THE CURRENT SEVERITY OF THE (claimed condition/diagnosis) GREATER THAN THE BASELINE?

- YES NO

IF YES, WAS THE VETERAN'S (claimed condition/diagnosis) AT LEAST AS LIKELY AS NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY (insert "service connected condition")?

- YES (provide rationale in section 6B.)
- NO (provide rationale in section 6B.)

Remark 2. Evidence review

My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C-file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review which clearly states that private examiners are not required to review any particular set of records or even to review the C-file at all (Nieves-Rodriguez v. Peake, 22 Vet. App. 295):

...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.

Such is the case where entitlement to service connection is clearly supported in the records available for my review. This is described in more detail in the rationale section below.

Remark 3. Question requiring a medical opinion

Has a causal nexus for service connection been established for the **RIGHT KNEE CONDITION?**

Remark 4. Direct service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating this condition in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disability considered holistically.

The STRs clearly indicate diagnosis of RIGHT KNEE OSTEOARTHRITIS WITH ACL TEAR on active duty. The initial manifestations of this condition never fully resolved after it arose on active duty. It remained symptomatic and developed into the chronic disability found today. According to my record review, as well as a detailed history and physical exam taken of Mr. [REDACTED] there has been continuity of symptoms from service to present. In addition, the development and progression of this condition as presented in the particular case of Mr. [REDACTED] is completely consistent with sound general medical principles as well as the consensus of expert medical opinion on the subject.

Each of the opinions below was rendered after reaching a certainty of **more likely than not - that is, the likelihood has a greater than 50 percent probability, or there is a preponderance of positive over negative evidence** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a current chronic disability of RIGHT KNEE OSTEOARTHRITIS WITH ACL TEAR.
- Mr. [REDACTED] had an in-service right knee illness.
- The current right knee condition was caused by the in-service right knee illness.
- The in-service right knee illness has persisted from the time of its first manifestation and developed into the current right knee condition.
- A causal nexus has been established for direct service connection of RIGHT KNEE OSTEOARTHRITIS WITH ACL TEAR.

Remark 5. Secondary service connection medical opinion with rationale

Not applicable.

Remark 6. Opinion regarding conflicting medical evidence

Not applicable.

Remark 7. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective - that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and **MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet. App. 259). In addition, I ask that clarification requests regarding my report not be directed to a C&P examiner, especially one of lesser credentials, who has no prior familiarity with Mr. [REDACTED] or this disability. Since I am readily available and responsive, such action by the VA "reasonably could be construed" as procuring evidence "for the sole purpose of denying the veteran's claim," also known as "developing to deny," an administrative practice that is rightly forbidden since it is~~

**INTERNAL VETERANS AFFAIRS USE
MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE**

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN [REDACTED]	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER [REDACTED]
---------------------------------------	--

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 VA 21 2507, 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: Remark 1,

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 will likely provide no additional relevant evidence.
- Review of available records in conjunction with an interview with the Veteran (without in person or 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
- VA claims file (hard copy paper C file)
- VA e folder
- VA electronic health record
- Other, please identify other evidence reviewed:
- No records were reviewed

Remark 2,

Evidence Comments:

Remark 2.

SECTION I - DEFINITIONS

AGGRAVATION OF PREEXISTING NONSERVICE CONNECTED DISABILITIES: A PREEXISTING INJURY OR DISEASE WILL BE CONSIDERED TO HAVE BEEN AGGRAVATED BY ACTIVE MILITARY, NAVAL, OR AIR SERVICE, WHERE THERE IS AN INCREASE IN DISABILITY DURING SUCH SERVICE, UNLESS THERE IS A SPECIFIC FINDING THAT THE INCREASE IN DISABILITY IS DUE TO THE NATURAL PROGRESS OF THE DISEASE.

AGGRAVATION OF NONSERVICE CONNECTED DISABILITIES: ANY INCREASE IN SEVERITY OF A NONSERVICE CONNECTED DISEASE OR INJURY THAT IS PROXIMATELY DUE TO OR THE RESULT OF A SERVICE CONNECTED DISEASE OR INJURY, AND NOT DUE TO THE NATURAL PROGRESS OF THE NONSERVICE CONNECTED DISEASE, WILL BE SERVICE CONNECTED.

SECTION II - RESTATEMENT OF REQUESTED OPINION

2A. INSERT REQUESTED OPINION FROM GENERAL REMARKS:

Left knee condition service connection; Remark 3.

2B. INDICATE TYPE OF EXAM FOR WHICH OPINION HAS BEEN REQUESTED (e.g. skin diseases): Knee.

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- 3A. THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 3B. THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (less than 50 percent probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

3C. RATIONALE:

Remark 4.

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

- 4A. THE CLAIMED CONDITION IS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.
- 4B. THE CLAIMED CONDITION IS LESS LIKELY THAN NOT (less than 50 percent probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.

4C. RATIONALE:

Remark 5.

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

- 5A. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 5B. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS CLEARLY AND UNMISTAKABLY NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

5C. RATIONALE:

Not applicable.

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. CAN YOU DETERMINE A BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition)?

- YES NO

IF "YES" TO QUESTION 6A, ANSWER THE FOLLOWING:

I. DESCRIBE THE BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition):

Not applicable.

II. PROVIDE THE DATE AND NATURE OF THE MEDICAL EVIDENCE USED TO PROVIDE THE BASELINE:

Not applicable.

III. IS THE CURRENT SEVERITY OF THE (claimed condition/diagnosis) GREATER THAN THE BASELINE?

- YES NO

IF YES, WAS THE VETERAN'S (claimed condition/diagnosis) AT LEAST AS LIKELY AS NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY (insert "service connected condition")?

- YES (provide rationale in section 6B.)
- NO (provide rationale in section 6B.)

Remark 2. Evidence review

My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C-file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review which clearly states that private examiners are not required to review any particular set of records or even to review the C-file at all (Nieves-Rodriguez v. Peake, 22 Vet. App. 295):

...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.

Such is the case where entitlement to service connection is clearly supported in the records available for my review. This is described in more detail in the rationale section below.

Remark 3. Question requiring a medical opinion

Has a causal nexus for service connection been established for the **LEFT KNEE CONDITION?**

Remark 4. Direct service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating this condition in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disability considered holistically.

The STRs clearly indicate diagnosis of LEFT KNEE OSTEOARTHRITIS on active duty. The initial manifestations of this condition never fully resolved after it arose on active duty. It remained symptomatic and developed into the chronic disability found today. According to my record review, as well as a detailed history and physical exam taken of Mr. [REDACTED] there has been continuity of symptoms from service to present. In addition, the development and progression of this condition as presented in the particular case of Mr. [REDACTED] is completely consistent with sound general medical principles as well as the consensus of expert medical opinion on the subject.

Each of the opinions below was rendered after reaching a certainty of **more likely than not - that is, the likelihood has a greater than 50 percent probability, or there is a preponderance of positive over negative evidence** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a current chronic disability of LEFT KNEE OSTEOARTHRITIS.
- Mr. [REDACTED] had an in-service left knee illness.
- The current left knee condition was caused by the in-service left knee illness.
- The in-service left knee illness has persisted from the time of its first manifestation and developed into the current left knee condition.
- A causal nexus has been established for direct service connection of LEFT KNEE OSTEOARTHRITIS.

Remark 5. Secondary service connection medical opinion with rationale

Not applicable.

Remark 6. Opinion regarding conflicting medical evidence

Not applicable.

Remark 7. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective - that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and **MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet. App. 259). In addition, I ask that clarification requests regarding my report not be directed to a C&P examiner, especially one of lesser credentials, who has no prior familiarity with Mr. [REDACTED] or this disability. Since I am readily available and responsive, such action by the VA "reasonably could be construed" as procuring evidence "for the sole purpose of denying the veteran's claim," also known as "developing to deny," an administrative practice that is rightly forbidden since it is~~

**INTERNAL VETERANS AFFAIRS USE
MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE**

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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 VA 21 2507, 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: Remark 1,

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 will likely provide no additional relevant evidence.
- Review of available records in conjunction with an interview with the Veteran (without in person or 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
- VA claims file (hard copy paper C file)
- VA e folder
- VA electronic health record
- Other, please identify other evidence reviewed:

Remark 2,

Evidence Comments:

Remark 2.

SECTION I - DEFINITIONS

AGGRAVATION OF PREEXISTING NONSERVICE CONNECTED DISABILITIES: A PREEXISTING INJURY OR DISEASE WILL BE CONSIDERED TO HAVE BEEN AGGRAVATED BY ACTIVE MILITARY, NAVAL, OR AIR SERVICE, WHERE THERE IS AN INCREASE IN DISABILITY DURING SUCH SERVICE, UNLESS THERE IS A SPECIFIC FINDING THAT THE INCREASE IN DISABILITY IS DUE TO THE NATURAL PROGRESS OF THE DISEASE.

AGGRAVATION OF NONSERVICE CONNECTED DISABILITIES: ANY INCREASE IN SEVERITY OF A NONSERVICE CONNECTED DISEASE OR INJURY THAT IS PROXIMATELY DUE TO OR THE RESULT OF A SERVICE CONNECTED DISEASE OR INJURY, AND NOT DUE TO THE NATURAL PROGRESS OF THE NONSERVICE CONNECTED DISEASE, WILL BE SERVICE CONNECTED.

SECTION II - RESTATEMENT OF REQUESTED OPINION

2A. INSERT REQUESTED OPINION FROM GENERAL REMARKS:

P&T status entitlement: Remark 3.

2B. INDICATE TYPE OF EXAM FOR WHICH OPINION HAS BEEN REQUESTED (e.g. skin diseases): P&T status.

SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

CHOOSE THE STATEMENT THAT MOST CLOSELY APPROXIMATES THE ETIOLOGY OF THE CLAIMED CONDITION.

- 3A. THE CLAIMED CONDITION WAS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 3B. THE CLAIMED CONDITION WAS LESS LIKELY THAN NOT (less than 50 percent probability) INCURRED IN OR CAUSED BY THE CLAIMED IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

3C. RATIONALE:

Remark 4.

SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

- 4A. THE CLAIMED CONDITION IS AT LEAST AS LIKELY AS NOT (50 percent or greater probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.
- 4B. THE CLAIMED CONDITION IS LESS LIKELY THAN NOT (less than 50 percent probability) PROXIMATELY DUE TO OR THE RESULT OF THE VETERAN'S SERVICE CONNECTED CONDITION. PROVIDE RATIONALE IN SECTION C.

4C. RATIONALE:

Remark 5.

SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

- 5A. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.
- 5B. THE CLAIMED CONDITION, WHICH CLEARLY AND UNMISTAKABLY EXISTED PRIOR TO SERVICE, WAS CLEARLY AND UNMISTAKABLY NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY AN IN SERVICE INJURY, EVENT, OR ILLNESS. PROVIDE RATIONALE IN SECTION C.

5C. RATIONALE:

Not applicable.

SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

6A. CAN YOU DETERMINE A BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition)?

- YES NO

IF "YES" TO QUESTION 6A, ANSWER THE FOLLOWING:

I. DESCRIBE THE BASELINE LEVEL OF SEVERITY OF (claimed condition/diagnosis) BASED UPON MEDICAL EVIDENCE AVAILABLE PRIOR TO AGGRAVATION OR THE EARLIEST MEDICAL EVIDENCE FOLLOWING AGGRAVATION BY (service connected condition):

Not applicable.

II. PROVIDE THE DATE AND NATURE OF THE MEDICAL EVIDENCE USED TO PROVIDE THE BASELINE:

Not applicable.

III. IS THE CURRENT SEVERITY OF THE (claimed condition/diagnosis) GREATER THAN THE BASELINE?

- YES NO

IF YES, WAS THE VETERAN'S (claimed condition/diagnosis) AT LEAST AS LIKELY AS NOT AGGRAVATED BEYOND ITS NATURAL PROGRESSION BY (insert "service connected condition")?

- YES (provide rationale in section 6B.)
- NO (provide rationale in section 6B.)

Remark 2. Evidence review

My evidence review included all relevant and available records from Mr. [REDACTED] entry into service, through his retirement, and up to the present time. This included his entire military personnel record, his entire service treatment record (STR), various private medical records, his entire VA health record, relevant portions of his C file, and an extensive set of various other documents. Due to the nature of this disability, the theory by which it is service connected, and the timeline of signs and symptoms by which the disability has manifested, I am certain that I have reviewed all the records that are necessary to form a sufficient basis for my conclusions. It is highly unlikely that any additional records would make any difference whatsoever in the adjudication of service connection of this disability. I have also reviewed the governing caselaw regarding evidence review, *Nieves Rodriguez v. Peake*, 22 Vet. App. 295, which clearly states that private examiners are not required to review any particular set of records or even to review the C file at all:

...the claims file is not a magical or talismanic set of documents ... Accordingly, the Court holds that claims file review, as it pertains to obtaining an overview of the claimant's medical history, is not a requirement for private medical opinions ... There are even instances where claims file review may be irrelevant to the medical issue at hand.

Such is the case where entitlement is not based on particular records but instead on a contemporaneous assessment of the permanence of a total disability. This is described in more detail in the rationale section below in Remark 4.

Remark 3. Question requiring a medical opinion

Has entitlement been established for **PERMANENT AND TOTAL (P&T) STATUS?**

Remark 4. Direct service connection medical opinion with rationale

Not applicable.

Remark 5. Secondary service connection medical opinion with rationale

I formed my opinion based on sound general medical principles, medical expertise from clinically treating these conditions in many patients, knowledge of the current peer-reviewed scientific literature as well as the consensus of expert medical opinion, military expertise, relevant facts and circumstances, review of records, an in-person examination, the Veteran's credible history and competent lay observations, and the actual functional limitations of his disabilities considered holistically.

P&T status becomes an ancillary rating issue when compensation evaluations combine to an overall rating that is total (M21-1 section V.ii.3.D.4.a). Consideration of whether or not a total rating is permanent then follows (M21-1 section XIII.i.1.A.1.h). Mr. [REDACTED] service connected disabilities have evaluations that combine to a total rating. These include conditions of tinnitus,

the neck and back, left lower extremity radiculopathy, right upper extremity neuropathy, the bilateral knees, the bilateral hips, the bilateral shoulders, the bilateral feet, and the bilateral elbows.

Mr. [REDACTED] overall impairment is permanent because it exhibits the following fact patterns: his disabilities are "permanent in character and of such nature that there is no likelihood of improvement" (38 CFR 3.327); his disabilities are "reasonably certain to continue throughout the life of the disabled person" (38 USC 3501 and 38 CFR 3.340, 4.15, and 21.3021); his disabilities have "manifestations reasonably certain to continue throughout the lifetime of the individual" (M21-1 section V.ii.3.D.4); and the evidence "at the time of evaluation affirmatively shows that the total disability will continue for the remainder of the person's life" (M21-1 section V.ii.3.D.4).

The underlying pathophysiology of his service connected disabilities is not temporary or transient. Though his symptoms may wax and wane over time, there is no reasonable prognosis for substantial or sustained improvement. Generally accepted medical principles, expert consensus, and ongoing medical research all indicate that the natural and expected disease course of his conditions is to remain symptomatic and progressively decline with age.

Each of the opinions below was rendered after reaching a certainty of **more likely than not - that is, the likelihood has a greater than 50 percent probability, or there is a preponderance of positive over negative evidence** (38 USC 5107(b); 38 CFR 3.102; Lynch v. McDonough, 21 F.4th 776; Jones v. Shinseki, 23 Vet. App. 382). My opinions are as follows:

- Mr. [REDACTED] has a total disability rating that is expected to continue indefinitely with at least the current level of severity according to the criteria of M21-1 section V.ii.3.D.4.d.
- Improvement of his disabilities is not likely.
- Reexamination to ascertain improvement is not warranted.
- A **clear and specific** evidentiary threshold for permanence has been met.
- Entitlement has been established for P&T status.

Remark 6. Opinion regarding conflicting medical evidence

Not applicable.

Remark 7. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily~~

DBQs

Name of Claimant/Veteran

Claimant/Veteran's Social Security Number

Date of Examination

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

Remark 1

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?

Remark 1.

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.

Remark 2.

SECTION I - DIAGNOSIS

Note: These are condition(s) for which an evaluation has been requested on an 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:

Back condition.

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, 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)
- Ankylosing spondylitis ICD Code: _____ Date of diagnosis: _____
- Degenerative arthritis ICD Code: M47.9 Date of diagnosis: 2000.
- Degenerative disc disease other than intervertebral disc syndrome (IVDS) ICD Code: _____ Date of diagnosis: _____
- Lumbosacral strain ICD Code: _____ Date of diagnosis: _____
- Intervertebral disc syndrome (Note: See VA definition of IVDS in Section XI.) ICD Code: _____ Date of diagnosis: _____
- Sacroiliac injury ICD Code: _____ Date of diagnosis: _____
- Sacroiliac weakness ICD Code: _____ Date of diagnosis: _____
- Segmental instability ICD Code: _____ Date of diagnosis: _____
- Spinal fusion ICD Code: _____ Date of diagnosis: _____
- Spinal stenosis ICD Code: _____ Date of diagnosis: _____
- Spondylolisthesis ICD Code: _____ Date of diagnosis: _____
- Traumatic paralysis, complete ICD Code: _____ Date of diagnosis: _____
- Vertebral dislocation ICD Code: _____ Date of diagnosis: _____
- Vertebral fracture ICD Code: _____ Date of diagnosis: _____
- Other (specify) ICD Code: _____ Date of diagnosis: _____
- Other diagnosis #1: _____ ICD Code: _____ Date of diagnosis: _____
- Other diagnosis #2: _____ ICD Code: _____ Date of diagnosis: _____
- Other diagnosis #3: _____ ICD Code: _____ Date of diagnosis: _____

1C. If there are additional diagnoses pertaining to thoracolumbar spine conditions, list using above format:

Remark 3.

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's thoracolumbar spine condition (brief summary):

Remark 4.

2B. Does the Veteran report flare ups of the thoracolumbar spine?

- Yes No

If yes, document the Veteran's description of the flare ups he/she experiences, including the frequency, duration, characteristics, precipitating and alleviating factors, severity, and/or extent of functional impairment he/she experiences during a flare up of symptoms:

Remark 4.

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

Note: For any joint condition, examiners should address pain on both passive and active motion, and on both weight bearing and nonweight bearing. If testing cannot be performed or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation must be given below. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).

Can testing be performed? Yes No

If no, provide an explanation:

Active Range of Motion (ROM) Perform active range of motion and provide the ROM values.

Forward flexion endpoint (90 degrees):	<u>30</u>	degrees	Left lateral flexion endpoint (30 degrees):	<u>10</u>	degrees
Extension endpoint (30 degrees):	<u>5</u>	degrees	Right lateral rotation endpoint (30 degrees):	<u>10</u>	degrees
Right lateral flexion endpoint (30 degrees):	<u>10</u>	degrees	Left lateral rotation endpoint (30 degrees):	<u>10</u>	degrees

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

Forward flexion
 Right lateral flexion
 Right lateral rotation
 Extension
 Left lateral flexion
 Left lateral rotation

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

Forward flexion:	<u>30</u>	Degree endpoint (if different than above)	Left lateral flexion:	<u>10</u>	Degree endpoint (if different than above)
Extension:	<u>5</u>	Degree endpoint (if different than above)	Right lateral rotation:	<u>10</u>	Degree endpoint (if different than above)
Right lateral flexion:	<u>10</u>	Degree endpoint (if different than above)	Left lateral rotation:	<u>10</u>	Degree endpoint (if different than above)

Remark 6.

Passive Range of Motion Perform passive range of motion and provide the ROM values.

Was passive range of motion testing performed? Yes No If not, indicate why passive range of motion testing was not performed:

- Medically contraindicated (e.g., it may cause the Veteran severe pain or the risk of further injury). It is not medically advisable to conduct passive range of motion testing because (provide explanation).
- Testing not necessary because (provide explanation).
- Other (provide explanation).

Explanation:

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

Forward flexion endpoint (90 degrees):	<u>60</u>	degrees	<input type="checkbox"/>	Same as active ROM
Extension endpoint (30 degrees):	<u>10</u>	degrees	<input type="checkbox"/>	Same as active ROM
Right lateral flexion endpoint (30 degrees):	<u>20</u>	degrees	<input type="checkbox"/>	Same as active ROM
Left lateral flexion endpoint (30 degrees):	<u>20</u>	degrees	<input type="checkbox"/>	Same as active ROM
Right lateral rotation endpoint (30 degrees):	<u>20</u>	degrees	<input type="checkbox"/>	Same as active ROM
Left lateral rotation endpoint (30 degrees):	<u>20</u>	degrees	<input type="checkbox"/>	Same as active ROM

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

<input checked="" type="checkbox"/> Forward flexion	<input checked="" type="checkbox"/> Right lateral flexion	<input checked="" type="checkbox"/> Right lateral rotation
<input checked="" type="checkbox"/> Extension	<input checked="" type="checkbox"/> Left lateral flexion	<input checked="" type="checkbox"/> Left lateral rotation

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

Forward flexion: _____	Degree endpoint (if different than above)	Left lateral flexion: _____	Degree endpoint (if different than above)
Extension: _____	Degree endpoint (if different than above)	Right lateral rotation: _____	Degree endpoint (if different than above)
Right lateral flexion: _____	Degree endpoint (if different than above)	Left lateral rotation: _____	Degree endpoint (if different than above)

Remark 6.

Is there evidence of pain? Yes No If yes check all that apply:

<input checked="" type="checkbox"/> Weight bearing	<input checked="" type="checkbox"/> Nonweight bearing	<input checked="" type="checkbox"/> Active motion	<input checked="" type="checkbox"/> Passive motion	<input type="checkbox"/> On rest/non movement
<input checked="" type="checkbox"/> Causes functional loss (if checked describe in the comments box below)		<input type="checkbox"/> Does not result in/cause functional loss		

Comments:

Remark 7.

Is there objective evidence of crepitus? Yes No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? Yes No

If yes, describe location, severity, and relationship to condition(s):

Remark 7.

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

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 completion of the three repetitions:

Forward flexion endpoint (90 degrees):	_____ degrees	Left lateral flexion endpoint (30 degrees):	_____ degrees
Extension endpoint (30 degrees):	_____ degrees	Right lateral rotation endpoint (30 degrees):	_____ degrees
Right lateral flexion endpoint (30 degrees):	_____ degrees	Left lateral rotation endpoint (30 degrees):	_____ degrees

Select all factors that cause this functional loss: (check all that apply) N/A Pain Fatigability Weakness Lack of endurance Incoordination
 Other:

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. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare ups even if not directly observed during a flare up and/or after repeated use over time.

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 all factors that cause this functional loss: (check all that apply) N/A Pain Fatigability Weakness Lack of endurance Incoordination
 Other:

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:

Forward flexion endpoint (90 degrees):	<u>30</u> degrees	Left lateral flexion endpoint (30 degrees):	<u>10</u> degrees
Extension endpoint (30 degrees):	<u>5</u> degrees	Right lateral rotation endpoint (30 degrees):	<u>10</u> degrees
Right lateral flexion endpoint (30 degrees):	<u>10</u> degrees	Left lateral rotation endpoint (30 degrees):	<u>10</u> degrees

The examiner should provide the estimated range of motion 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):

Remark 8.

3D. Flare ups

Is the Veteran being examined 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

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

Select all factors that cause this functional loss: (check all that apply) N/A Pain Fatigability Weakness Lack of endurance Incoordination Other:

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:

Forward flexion endpoint (90 degrees):	<u>30</u> degrees	Left lateral flexion endpoint (30 degrees):	<u>10</u> degrees
Extension endpoint (30 degrees):	<u>5</u> degrees	Right lateral rotation endpoint (30 degrees):	<u>10</u> degrees
Right lateral flexion endpoint (30 degrees):	<u>10</u> degrees	Left lateral rotation endpoint (30 degrees):	<u>10</u> degrees

The examiner should provide the estimated range of motion 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):

Remark 8.

3E. Guarding and muscle spasm

Does the Veteran have localized tenderness, guarding or muscle spasm of the thoracolumbar spine?

Yes No

Localized tenderness:

- None
- Not resulting in abnormal gait or abnormal spinal contour

Provide description and/or etiology:

Remark 9.

Muscle spasm:

- None
- Resulting in abnormal gait or abnormal spine contour
- Not resulting in abnormal gait or abnormal spinal contour
- Unable to evaluate, describe below:

Provide description and/or etiology:

Remark 9.

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

Guarding:

- None
- Resulting in abnormal gait or abnormal spine contour
- Not resulting in abnormal gait or abnormal spinal contour
- Unable to evaluate, describe below:

Provide description and/or etiology:

Remark 9.

3F. 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:

- None
- Interference with sitting
- Interference with standing
- Swelling
- Deformity
- Disturbance of locomotion
- Less movement than normal
- More movement than normal
- Weakened movement
- Atrophy of disuse
- Instability of station
- Other, describe:

Please describe additional contributing factors of disability:

Remark 9.

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

Side	Flexion/ Extension	Rate Strength	Flexion/ Extension	Rate Strength	Side	Flexion/ Extension	Rate Strength	Flexion/ Extension	Rate Strength
Right	Hip Flexion	5 /5	Ankle Dorsiflexion	5 /5	Left	Hip Flexion	4 /5	Ankle Dorsiflexion	4 /5
	Knee Extension	5 /5	Great Toe Extension	5 /5		Knee Extension	4 /5	Great Toe Extension	4 /5
	Ankle Plantar Flexion	5 /5				Ankle Plantar Flexion	4 /5		

4B. Does the Veteran have muscle atrophy?

- Yes
- No

SECTION IV - MUSCLE STRENGTH TESTING (continued)

4C. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section?

Yes No

If no, provide rationale:

4D. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.

Provide measurements in centimeters of normal side and atrophied side, measured at maximum muscle bulk.

Circumference of normal side: _____ cm Circumference of atrophied side: _____ cm

SECTION V - REFLEX EXAM

5A. Rate deep tendon reflexes (DTRs) according to the following scale:

0 Absent				
1+ Hypoactive	Right:	Knee: 2 +	Ankle: 2 +	
2+ Normal				
3+ Hyperactive without clonus	Left:	Knee: 1 +	Ankle: 1 +	
4+ Hyperactive with clonus				

SECTION VI - SENSORY EXAM

6A. Provide results for sensation to light touch (dermatome) testing:

Side	Upper Anterior Thigh (L2)		Thigh/Knee (L3/4)		Lower Leg/Ankle (L4/L5/S1)		Foot/Toes (L5)	
Right	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased <input type="checkbox"/> Absent	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased <input type="checkbox"/> Absent	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased <input type="checkbox"/> Absent	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased <input type="checkbox"/> Absent
Left	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Decreased <input type="checkbox"/> Absent	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Decreased <input type="checkbox"/> Absent	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Decreased <input type="checkbox"/> Absent	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Decreased <input type="checkbox"/> Absent

Other sensory findings, if any:

Remark 10.

SECTION VII - STRAIGHT LEG RAISING TEST

Note: This test can be performed with the Veteran seated or supine. Raise each straightened leg until pain begins, typically at 30 70 degrees of elevation. The test is positive if the pain radiates below the knee, not merely limited to the back or hamstring muscles. Pain is often increased on dorsiflexion of the foot, and relieved by knee flexion. A positive test suggests radiculopathy, often due to disc herniation.

7A. Provide straight leg raising test results:

Right: Negative Positive Unable to perform
Left: Negative Positive Unable to perform

If "Unable to perform," please explain:

Remark 10.

SECTION VIII - RADICULOPATHY

Note: For purposes of this examination, the diagnoses of IVDS and radiculopathy can be made by a history of characteristic radiating pain and/or sensory changes in the legs, and objective clinical findings, which may include the asymmetrical loss or decrease of reflexes, decreased strength and/or abnormal sensation. Electromyography (EMG) studies are rarely required to diagnose radiculopathy in the appropriate clinical setting.

Does the Veteran have radicular pain or any other signs or symptoms due to radiculopathy?

Yes No If yes, complete sections 8A 8D.

8A. Indicate symptoms' location and severity (check all that apply):

Note: For VA purposes, when the involvement is wholly sensory, the evaluation should be for the mild, or at the most, the moderate degree.

Constant pain (may be excruciating at times):	Right lower extremity:	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
	Left lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input checked="" type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Intermittent pain (usually dull):	Right lower extremity:	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
	Left lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input checked="" type="checkbox"/> Severe
Paresthesias and/or dysesthesias:	Right lower extremity:	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
	Left lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input checked="" type="checkbox"/> Severe
Numbness:	Right lower extremity:	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
	Left lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input checked="" type="checkbox"/> Severe

8B. Does the Veteran have any other signs or symptoms of radiculopathy?

Yes No

If yes, describe:

Remark 11.

8C. Indicate nerve roots involved (check all that apply):

Involvement of L2/L3/L4 nerve roots (femoral nerve)
If checked, indicate side affected: Right Left Both

Involvement of L4/L5/S1/S2/S3 nerve roots (sciatic nerve)
If checked, indicate side affected: Right Left Both

Other nerves (specify nerve and side(s) affected):
If checked, indicate side affected: Right Left Both

SECTION VIII - RADICULOPATHY (continued)

8D. For any abnormal or positive identified neurological findings identified in Sections 4 8, explain the likely cause of those identified symptoms:

Remark 11.

SECTION IX - ANKYLOSIS

Note: For VA compensation purposes, unfavorable ankylosis is a condition in which the entire cervical spine, the entire thoracolumbar spine, or the entire spine is fixed in flexion or extension, and the ankylosis results in one or more of the following: difficulty walking because of a limited line of vision; restricted opening of the mouth and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms due to pressure of the costal margin on the abdomen; dyspnea or dysphagia; atlantoaxial or cervical subluxation or dislocation; or neurologic symptoms due to nerve root stretching. Fixation of a spinal segment in neutral position (zero degrees) always represents favorable ankylosis.

9A. Is there ankylosis of the spine?

Yes No If yes, indicate severity of ankylosis:

Unfavorable ankylosis of the entire spine Unfavorable ankylosis of the entire thoracolumbar spine Favorable ankylosis of the entire thoracolumbar spine

9B. Comments, if any:

SECTION X - OTHER NEUROLOGIC ABNORMALITIES

10A. Does the Veteran have any other neurologic abnormalities or findings (other than those identified in Sections 4 8) related to a thoracolumbar spine condition (such as bowel or bladder problems/pathologic reflexes)?

Yes No

If yes, describe condition and how it is related:

Note: If there are neurological abnormalities other than radiculopathy, also complete appropriate questionnaire for each condition identified.

SECTION XI - INTERVERTEBRAL DISC SYNDROME (IVDS) AND EPISODES REQUIRING BED REST

Note: IVDS is a group of signs and symptoms due to disc herniation with compression and/or irritation of the adjacent nerve root that commonly includes back pain and sciatica (pain along the course of the sciatic nerve) in the case of lumbar disc disease, and neck and arm or hand pain in the case of cervical disc disease. Imaging studies are not required to make the diagnosis of IVDS.

11A. Does the Veteran have IVDS of the thoracolumbar spine?

Yes No

11B. If yes to question 11A above, has the Veteran had any episodes of acute signs and symptoms due to IVDS that required bed rest prescribed by a physician and treatment by a physician in the past 12 months?

Yes No

If yes select the total duration over the past 12 months:

- With no episodes of bed rest during the past 12 months
- With episodes of bed rest having a total duration of at least 1 week but less than 2 weeks during the past 12 months
- With episodes of bed rest having a total duration of at least 2 weeks but less than 4 weeks during the past 12 months
- With episodes of bed rest having a total duration of at least 4 weeks but less than 6 weeks during the past 12 months
- With episodes of bed rest having a total duration of at least 6 weeks during the past 12 months

SECTION XI - INTERVERTEBRAL DISC SYNDROME (IVDS) AND EPISODES REQUIRING BED REST (continued)

11C. If yes to question 11B above, provide the following documentation that supports the yes response:

Medical history as described by the Veteran only, without documentation:

Medical history as shown and documented in the Veteran's file.
Individual date(s) of each treatment record(s) reviewed:

Facility/provider:

Describe treatment:

Other, describe:

SECTION XII - ASSISTIVE DEVICES

12A. 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):

<input type="checkbox"/> Wheelchair	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Brace	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Crutches	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Cane	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Walker	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Other: _____	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant

12B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

Remark 12.

SECTION XIII - 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.

13A. Due to the Veteran's thoracolumbar spine 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 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):

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

14A. 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):

Remark 12.

14B. 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?

Yes No

If yes, complete appropriate dermatological questionnaire.

14C. Comments, if any:

Remark 12.

SECTION XV - 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, no further imaging studies are required by VA, even if arthritis has worsened.

Imaging studies are not required to make the diagnosis of IVDS. Electromyography (EMG) studies are rarely required to diagnose radiculopathy in the appropriate clinical setting.

15A. Have imaging studies been performed in conjunction with this examination?

Yes No

15B. If yes, is degenerative or post traumatic arthritis documented?

Yes No

15C. If yes, provide type of test or procedure, date and results (brief summary):

Remark 13.

15D. Does the Veteran have imaging evidence of a thoracolumbar vertebral fracture with loss of 50 percent or more of height?

Yes No N/A

15E. Are there any other significant 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):

Remark 13.

15F. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

Remark 13.

Remark 3. Diagnosis

The dates of diagnosis on this DBQ may differ from those found elsewhere, especially in C&P exams. The VA provides clear and unambiguous direction on this matter in a note on all of its DBQs: "Date of diagnosis can be. . . **AN APPROXIMATE DATE DETERMINED THROUGH RECORD REVIEW OR REPORTED HISTORY.**" It is common practice for C&P examiners to disregard this guidance along with the reported history from the Veteran. Instead, they often record the date when a medical record first contains a diagnosis despite no requirement whatsoever from the VA to have such a correspondence on the DBQs. In contrast, I have completed a careful record review and medical history to determine the approximate date of some observable sign or symptom that was the first manifestation of a disability. This date most accurately reflects the beginning of impairment. It often long precedes the date in a medical record, sometimes by many years. There are no additional diagnoses.

Remark 4. Medical history

See associated medical opinion for medical history.

Flare-ups: "Flare-ups interfere with all of my work and activities of daily living."

Repeated use over time: "Repeated use over time results in increased symptoms which interfere with walking, standing, kneeling, lifting, carrying, squatting, and stairs."

Remark 5. Functional loss

Loss of ROM limits the ability to function normally because it degrades the operation of skeletal joints in all domains of normally expected capability in an occupational environment.

Remark 6. Active & Passive ROM

ACTIVE ROM: joint movements were measured in the standing position with a 25 pound dumbbell held in each hand. This loaded the joints to simulate actual function in a physically demanding, non-sedentary occupational environment. This also measured ROM under "**WEIGHT-BEARING**" conditions which is most sensibly done during measurement of active ROM.

PASSIVE ROM: joint movements were measured only against the resistance of gravity - that is, without dumbbells held in the hands. This unloaded the joints to the maximum practical extent to best simulate function in a lighter duty, sedentary occupational environment. This also to measured ROM under "**NONWEIGHT-BEARING**" conditions which is most sensibly done during measurement of passive ROM.

The proper examination of joint ROM is addressed further in an additional appendix.

Remark 7. Evidence of pain

ROM was limited by pain. Loss of ROM limits the ability to function normally because it degrades the operation of skeletal joints in all domains of normally expected capability in an

occupational environment. Crepitus in the thoracolumbar spine is due to the claimed condition. The thoracolumbar spine and associated soft tissues were moderately tender due to the claimed condition.

Remark 8. Estimated ROM after repeated use over time and during flare-ups

The estimated ROM was based on all procurable evidence including my medical expertise as well as a thorough medical history incorporating lay statements from the Veteran.

Remark 9. Guarding and additional factors contributing to disability

The thoracolumbar spine and associated soft tissues were moderately tender due to the claimed condition. Muscle spasms and guarding were present in the thoracolumbar spine and associated soft tissues and caused abnormal gait and contour due to the claimed condition. The selected factors contribute to disability by interfering with the normal mechanical functions of the body which then leads to difficulty with the basic activities of daily living.

Remark 10. Sensory findings

Lower extremities:	Right:	Left:
Vibratory sense (tuning fork):	Normal.	Decreased.
Cold sense (side of tuning fork):	Normal.	Decreased.
Soft sense (brush):	Normal.	Decreased.
Sharp sense (pin):	Normal.	Decreased.
Proprioception sense (position):	Normal.	Decreased.

Straight leg raising test:	Right:	Left:
	Negative	Positive

Remark 11. Radiculopathy

The radiculopathy symptoms are due to the claimed condition of left sciatic radiculopathy.

Remark 12. Assistive devices, other findings, and scars

Not applicable.

Remark 13. Diagnostic testing

Thoracolumbar degenerative arthritis was identified on x-ray studies. Reports enclosed. The abnormal imaging results are due to the claimed condition.

Remark 14. Functional impact

All occupational tasks (sedentary and non-sedentary) are impacted due to interference with walking, standing, kneeling, lifting, carrying, squatting, and stairs, and due to distraction and lack of concentration from chronic pain.

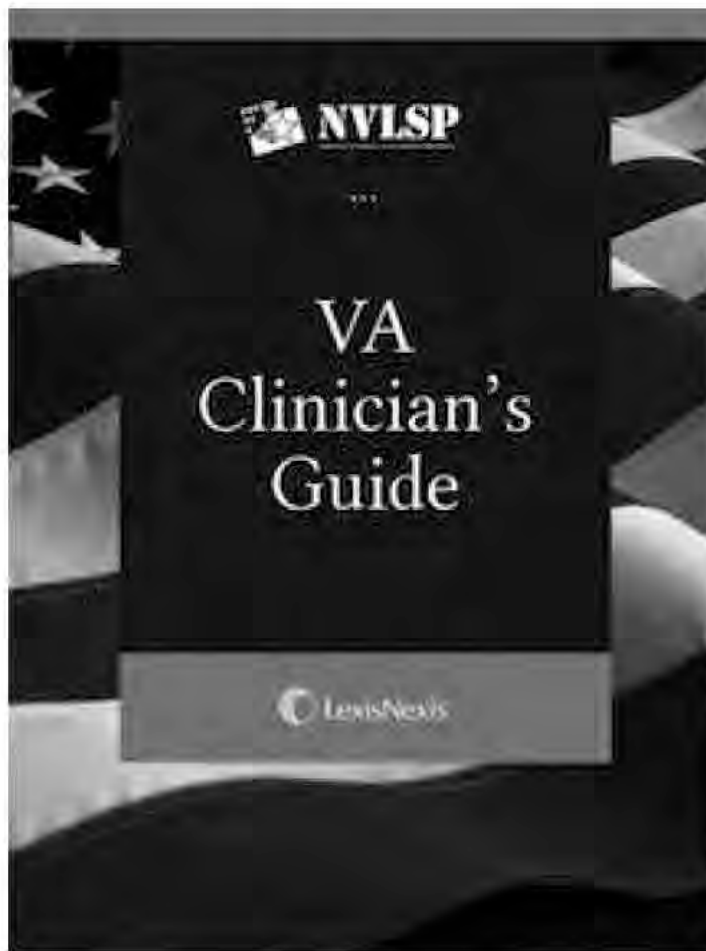
Commentary on range of motion measurement:

For this DBQ, I measured all ranges of motion (ROM) with a goniometer in accordance with VA DEMO training (1). I assessed active ROM “against gravity and strong resistance” according to the VA Clinician’s Guide (2). This practice also reflects an expert consensus from the field of disability medicine that active and passive ROM should differ significantly in affected joints when assessed properly, and that active ROM best captures the actual level of disability and functional loss in comparison to passive ROM (3-14).

"Active" ROM is joint movement performed by activation of the governing muscles against some form of strong resistance, whereas "passive" ROM is produced by an external force to evaluate the freedom and ROM of a joint when all muscles are relaxed (4). According to numerous treatises, active ROM is far more consistent between examiners (i.e., it has a higher inter-rater reliability factor). It is also a better indicator of joint function during occupational tasks and normal activities of daily living (5-14). Importantly, according to the AMA Guides, active ROM is a more sensitive and reliable indicator of joint loss of motion and must take precedence over passive ROM in disability examinations (4). Since passive ROM is measured with the muscles relaxed, then by definition it does not fully assess “functional” loss. The joint movements required for occupational purposes always requires muscular action. In other words, there are not any jobs that only involve passive joint ROM. Passive ROM therefore does not completely reflect the actual impairment of normal working movements of the body with regard to excursion, strength, speed, coordination, and endurance. Further, "pain on use" is best observed during active ROM as that assesses the joint mechanism as a musculoskeletal system and not as a point of skeletal articulation isolated from the musculature.

Citations:

1. Bagley C. Musculoskeletal Exam. DEMO training. VHA. 12-09-2015.
2. Coulson LR. Clinician Guide 3.0. DVA: VHA and C&P Service. March 2002.
3. Gerhardt JJ. The Practical Guide to Range of Motion Assessment. Chicago, IL: AMA; 2002.
4. Rondinelli RD. Guides to the Evaluation of Permanent Impairment, 6th Edition. AMA; 2021.
5. Amis AA, Miller JH. The elbow. Clin Rheum Dis. 1982;8:571-593.
6. Bird HA, Stowe J. The wrist. Clin Rheum Dis. 1982;8:559-569.
7. Horger MM. The reliability of goniometric measurements of active and passive wrist motions. Am J Occup Ther. 1990;44:342-348.
8. Potney LG. Foundations of Clinical Research: Applications to Practice. Appleton; 1993.
9. Shrout PE. Intraclass correlations: uses in assessing rater reliability. Psychol Bull. 1979;86:420-428.
10. Youdas JW. Reliability of goniometric measurements and visual estimates of ankle joint active range of motion obtained in a clinical setting. Arch Phys Med Rehabil. 1993; 74:1113-1118.
11. Bohannon RW. Cybex II isokinetic dynamometer for passive load application and measurement: suggestion from the field. Phys Ther. 1986;66:1407.
12. Pandya S. Reliability of goniometric measurements in patients with Duchenne muscular dystrophy. Phys Ther. 1985; 65:1339-1342.
13. Dvorak J. Clinical validation of functional flexion/extension radiographs of the cervical spine. Spine. 1993; 18:120-127.
14. Flowers KR. Assessment and management of loss of motion in orthopaedic dysfunction. Postgrad Adv Phys Ther. PTA; 1988:1-11.



Clinician Guide version 3.0
Edited by Lewis R. Coulson, M.D.
March 2002

Purpose of the Clinician's Guide

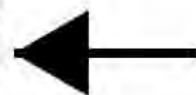
This guide is designed to assist clinicians when performing compensation and pension (C&P) examinations. Since C&P examinations differ markedly from traditional medical examinations, special clinician guidance is required. This guide provides information for performing examinations that meet the requirements of the federal law. ←

Since the federal law (rating schedule) is written in legal language, it is often misinterpreted by clinicians. This guide, therefore, bridges this gap and explains the law in clinical terms.

Both this Guide and the worksheets should be utilized when performing C&P examinations.

11.2. What are the important factors in range-of-motion testing?

- a. Accurate assessment of joint range-of-motion (ROM) is extremely important. See worksheets for standardized descriptions of “average normal” joint motion measurements for the upper and lower extremities.
- b. Use a **goniometer** to measure both passive and active ROM, including movement against gravity and strong resistance. **Provide ROM in degrees**; it is **not acceptable** simply to note that range of motion is “normal” or “within normal limits.”
- c. It is good practice to include ROM of the contralateral joint whenever possible. This is particularly true if joint ROM is felt to be “normal,” but the measured ROM in degrees is different from the **average** normal ROM shown in the worksheets.
- d. Report the joint range of motion with reference to the anatomic position, e.g., state that “elbow flexion is 0 to 120 degrees”, rather than “elbow flexion is **limited by** 25 degrees” or “elbow flexion is **limited to** 120 degrees” or “the elbow **lacks** 25 degrees of full flexion”. Reporting range of motion any other way than by referring to the anatomic position leads to confusion among raters and may result in incorrect disability evaluations.
- e. The “anatomic position” is defined as the patient standing erect with feet flat on the floor, heels together, arms at the sides, palms facing forward, fingers and thumbs extended parallel to hands, and chin straight forward.



Name of Claimant/Veteran
 [REDACTED]

 Claimant/Veteran's Social Security Number
 [REDACTED]

 Date of Examination
 [REDACTED]

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

Remark 1.

 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?

Remark 1.

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.

Remark 2.

DOMINANT HAND

Dominant hand:

 Right

 Left

 Ambidextrous

SECTION I - DIAGNOSIS

Note: These are condition(s) for which an evaluation has been requested on an 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:

Neck condition.

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, 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.

SECTION I - DIAGNOSIS (continued)

1B. Select diagnoses associated with the claimed condition(s) (check all that apply):

<input type="checkbox"/>	The Veteran does not have a current diagnosis associated with any claimed conditions listed above. (Explain your findings and reasons in the remarks section)		
<input type="checkbox"/>	Ankylosing spondylitis	ICD Code: _____	Date of diagnosis: _____
<input checked="" type="checkbox"/>	Cervical strain	ICD Code: <u>S13.4</u>	Date of diagnosis: <u>2017.</u>
<input type="checkbox"/>	Degenerative arthritis	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Degenerative disc disease other than intervertebral disc syndrome (IVDS)	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Intervertebral disc syndrome (Note: See VA definition of IVDS in Section X.)	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Segmental instability	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Spinal fusion	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Spinal stenosis	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Spondylolisthesis	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Vertebral dislocation	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Vertebral fracture	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Traumatic paralysis, complete	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Other (specify)	ICD Code: _____	Date of diagnosis: _____
	Other diagnosis #1: _____	ICD Code: _____	Date of diagnosis: _____
	Other diagnosis #2: _____	ICD Code: _____	Date of diagnosis: _____
	Other diagnosis #3: _____	ICD Code: _____	Date of diagnosis: _____

1C. If there are additional diagnoses pertaining to cervical spine conditions, list using above format:

Remark 3.

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's cervical spine condition (brief summary):

Remark 4.

2B. Does the Veteran report flare ups of the cervical spine?

Yes No

If yes, document the Veteran's description of the flare ups he/she experiences, including the frequency, duration, characteristics, precipitating and alleviating factors, severity, and/or extent of functional impairment he/she experiences during a flare up of symptoms:

Remark 4.

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.

Remark 4.

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

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.

3A. Initial ROM measurements

- All normal
- Abnormal or outside of normal range
- Unable to test
- Not indicated

If "Unable to test" or "Not indicated", please explain:

If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than a neck condition, such as age, body habitus, neurologic disease), please describe:

If abnormal, does the range of motion itself contribute to a functional loss? Yes No

If yes, please explain:

Remark 5.

Note: For any joint condition, examiners should address pain on both passive and active motion, and on both weight bearing and nonweight bearing. If testing cannot be performed or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation must be given below. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).

Can testing be performed? Yes No

If no, provide an explanation:

Active Range of Motion (ROM) Perform active range of motion and provide the ROM values.

Forward flexion endpoint (45 degrees):	<u>30</u> degrees	Left lateral flexion endpoint (45 degrees):	<u>20</u> degrees
Extension endpoint (45 degrees):	<u>10</u> degrees	Right lateral rotation endpoint (80 degrees):	<u>40</u> degrees
Right lateral flexion endpoint (45 degrees):	<u>20</u> degrees	Left lateral rotation endpoint (80 degrees):	<u>40</u> degrees

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATIONS (continued)

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

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Forward flexion | <input checked="" type="checkbox"/> Right lateral flexion | <input checked="" type="checkbox"/> Right lateral rotation |
| <input checked="" type="checkbox"/> Extension | <input checked="" type="checkbox"/> Left lateral flexion | <input checked="" type="checkbox"/> Left lateral rotation |

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

Forward flexion	<u>30</u>	Degree endpoint (if different than above)	Left lateral flexion	<u>20</u>	Degree endpoint (if different than above)
Extension	<u>10</u>	Degree endpoint (if different than above)	Right lateral rotation	<u>40</u>	Degree endpoint (if different than above)
Right lateral flexion	<u>20</u>	Degree endpoint (if different than above)	Left lateral rotation	<u>40</u>	Degree endpoint (if different than above)

Remark 6.

Passive Range of Motion Perform passive range of motion and provide the ROM values.

Was passive range of motion testing performed? Yes No If not, indicate why passive range of motion testing was not performed:

- Medically contraindicated (e.g., it may cause the Veteran severe pain or the risk of further injury). It is not medically advisable to conduct passive range of motion testing because (provide explanation).
- Testing not necessary because (provide explanation).
- Other (provide explanation).

Explanation:

Forward flexion endpoint (45 degrees):	<u>40</u>	degrees	<input type="checkbox"/> Same as active ROM
Extension endpoint (45 degrees):	<u>20</u>	degrees	<input type="checkbox"/> Same as active ROM
Right lateral flexion endpoint (45 degrees):	<u>30</u>	degrees	<input type="checkbox"/> Same as active ROM
Left lateral flexion endpoint (45 degrees):	<u>30</u>	degrees	<input type="checkbox"/> Same as active ROM
Right lateral rotation endpoint (80 degrees):	<u>55</u>	degrees	<input type="checkbox"/> Same as active ROM
Left lateral rotation endpoint (80 degrees):	<u>55</u>	degrees	<input type="checkbox"/> Same as active ROM

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

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Forward flexion | <input checked="" type="checkbox"/> Right lateral flexion | <input checked="" type="checkbox"/> Right lateral rotation |
| <input checked="" type="checkbox"/> Extension | <input checked="" type="checkbox"/> Left lateral flexion | <input checked="" type="checkbox"/> Left lateral rotation |

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

Forward flexion	<u>40</u>	Degree endpoint (if different than above)	Left lateral flexion	<u>30</u>	Degree endpoint (if different than above)
Extension	<u>20</u>	Degree endpoint (if different than above)	Right lateral rotation	<u>30</u>	Degree endpoint (if different than above)
Right lateral flexion	<u>55</u>	Degree endpoint (if different than above)	Left lateral rotation	<u>55</u>	Degree endpoint (if different than above)

Remark 6.

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATIONS (continued)

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
 Causes functional loss (if checked describe in the comments box below) Does not result in/cause functional loss

Comments:

Remark 7.

Is there objective evidence of crepitus? Yes No
 Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? Yes No

If yes, describe location, severity, and relationship to condition(s):

Remark 7.

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 completion of the three repetitions:

Forward flexion endpoint (45 degrees):	_____ degrees	Left lateral flexion endpoint (45 degrees):	_____ degrees
Extension endpoint (45 degrees):	_____ degrees	Right lateral rotation endpoint (80 degrees):	_____ degrees
Right lateral flexion endpoint (45 degrees):	_____ degrees	Left lateral rotation endpoint (80 degrees):	_____ degrees

Select all factors that cause this functional loss: (check all that apply) N/A Pain Fatigability Weakness Lack of endurance Incoordination
 Other:

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATIONS (continued)

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. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare ups even if not directly observed during a flare up and/or after repeated use over time.

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 all factors that cause this functional loss: (check all that apply) N/A Pain Fatigability Weakness Lack of endurance Incoordination Other:

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:

Forward flexion endpoint (45 degrees):	<u>30</u>	degrees	Left lateral flexion endpoint (45 degrees):	<u>20</u>	degrees
Extension endpoint (45 degrees):	<u>10</u>	degrees	Right lateral rotation endpoint (80 degrees):	<u>40</u>	degrees
Right lateral flexion endpoint (45 degrees):	<u>20</u>	degrees	Left lateral rotation endpoint (80 degrees):	<u>40</u>	degrees

The examiner should provide the estimated range of motion 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):

Remark 8.

3D. Flare ups

Is the Veteran being examined 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 all factors that cause this functional loss: (check all that apply) N/A Pain Fatigability Weakness Lack of endurance Incoordination Other:

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:

Forward flexion endpoint (45 degrees):	<u>30</u>	degrees	Left lateral flexion endpoint (45 degrees):	<u>20</u>	degrees
Extension endpoint (45 degrees):	<u>10</u>	degrees	Right lateral rotation endpoint (80 degrees):	<u>40</u>	degrees
Right lateral flexion endpoint (45 degrees):	<u>20</u>	degrees	Left lateral rotation endpoint (80 degrees):	<u>40</u>	degrees

The examiner should provide the estimated range of motion 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):

Remark 8.

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATIONS (continued)

3E. Guarding and muscle spasm

Does the Veteran have localized tenderness, guarding or muscle spasm of the cervical spine?

Yes No

Localized tenderness:

- None
- Not resulting in abnormal gait or abnormal spinal contour

Provide description and/or etiology:

Remark 9.

Muscle spasm:

- None
- Resulting in abnormal gait or abnormal spine contour
- Not resulting in abnormal gait or abnormal spinal contour
- Unable to evaluate, describe below:

Provide description and/or etiology:

Remark 9.

Guarding:

- None
- Resulting in abnormal gait or abnormal spine contour
- Not resulting in abnormal gait or abnormal spinal contour
- Unable to evaluate, describe below:

Provide description and/or etiology:

Remark 9.

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATIONS (continued)

3F. 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:

- None Interference with sitting Interference with standing Swelling Deformity
 Disturbance of locomotion Less movement than normal More movement than normal Weakened movement Atrophy of disuse
 Instability of station Other, describe:

Please describe additional contributing factors of disability:

Remark 9.

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

Side	Flexion/ Extension	Rate Strength	Flexion/ Extension	Rate Strength	Side	Flexion/ Extension	Rate Strength	Flexion/ Extension	Rate Strength
Right	Elbow Flexion	5 /5	Wrist Extension	5 /5	Left	Elbow Flexion	5 /5	Wrist Extension	5 /5
	Elbow Extension	5 /5	Finger Flexion	5 /5		Elbow Extension	5 /5	Finger Flexion	5 /5
	Wrist Flexion	4 /5	Finger Abduction	4 /5		Wrist Flexion	5 /5	Finger Abduction	5 /5

4B. Does the Veteran have muscle atrophy?

- Yes No

4C. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section?

- Yes No

If no, provide rationale:

4D. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.

Provide measurements in centimeters of normal side and atrophied side, measured at maximum muscle bulk.

Circumference of normal side: _____ cm Circumference of atrophied side: _____ cm

SECTION V - REFLEX EXAM

5A. Rate deep tendon reflexes (DTRs) according to the following scale:

0 Absent							
1+ Hypoactive	Right:	Bicep:	2 +	Tricep:	2 +	Brachoradialis:	1 +
2+ Normal							
3+ Hyperactive without clonus	Left:	Bicep:	2 +	Tricep:	2 +	Brachoradialis:	2 +
4+ Hyperactive with clonus							

SECTION VI - SENSORY EXAM

6A. Provide results for sensation to light touch (dermatome) testing:

Side	Shoulder Area (C5)			Inner/Outer Forearm (C6 T1)			Hand/Fingers (C6 8)		
Right	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Left	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent

Other sensory findings, if any:

Remark 10.

SECTION VII - RADICULOPATHY

Note: For purposes of this examination, the diagnoses of IVDS and radiculopathy can be made by a history of characteristic radiating pain and/or sensory changes in the legs, and objective clinical findings, which may include the asymmetrical loss or decrease of reflexes, decreased strength and/or abnormal sensation. Electromyography (EMG) studies are rarely required to diagnose radiculopathy in the appropriate clinical setting.

Does the Veteran have radicular pain or any other signs or symptoms due to radiculopathy?

Yes No

If yes, complete sections 7A - 7D.

7A. Indicate symptoms' location and severity (check all that apply):

Note: For VA purposes, when the involvement is wholly sensory, the evaluation should be mild, or no more than moderate.

Constant pain (may be excruciating at times):	Right upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
	Left upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Intermittent pain (usually dull):	Right upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
	Left upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Paresthesias and/or dysesthesias:	Right upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
	Left upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Numbness:	Right upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
	Left upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

7B. Does the Veteran have any other signs or symptoms of radiculopathy?

Yes No

If yes, describe:

Remark 11.

SECTION VII - RADICULOPATHY (continued)

7C. Indicate nerve roots involved (check all that apply):

- Involvement of C5/C6 nerve roots (upper radicular group): If checked, indicate: Right Left Both
- Involvement of C7 nerve root (middle radicular group): If checked, indicate: Right Left Both
- Involvement of C8/T1 nerve roots (lower radicular group): If checked, indicate: Right Left Both

7D: For any abnormal or positive identified neurological findings identified in Sections 4-7, explain the likely cause of those identified symptoms:

Remark 11.

SECTION VIII - ANKYLOSIS

Note: For VA compensation purposes, unfavorable ankylosis is a condition in which the entire cervical spine, the entire thoracolumbar spine, or the entire spine is fixed in flexion or extension, and the ankylosis results in one or more of the following: difficulty walking because of a limited line of vision; restricted opening of the mouth and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms due to pressure of the costal margin on the abdomen; dyspnea or dysphagia; atlantoaxial or cervical subluxation or dislocation; or neurologic symptoms due to nerve root stretching. Fixation of a spinal segment in neutral position (zero degrees) always represents favorable ankylosis.

8A. Is there ankylosis of the spine?

- Yes No If yes, indicate severity of ankylosis:
- Unfavorable ankylosis of the entire spine Unfavorable ankylosis of the entire cervical spine Favorable ankylosis of the entire cervical spine

8B. Comments, if any:

SECTION IX - OTHER NEUROLOGIC ABNORMALITIES

9A. Does the Veteran have any other neurologic abnormalities or findings (other than those identified in Sections 4-7) related to a cervical spine condition (such as bowel or bladder problems/pathologic reflexes)?

- Yes No

If yes, describe condition and how it is related:

Remark 11.

Note: If there are neurological abnormalities other than radiculopathy, also complete appropriate questionnaire for each condition identified.

SECTION X - INTERVERTEBRAL DISC SYNDROME (IVDS) AND EPISODES REQUIRING BED REST

Note: IVDS is a group of signs and symptoms due to disc herniation with compression and/or irritation of the adjacent nerve root that commonly includes back pain and sciatica (pain along the course of the sciatic nerve) in the case of lumbar disc disease, and neck and arm or hand pain in the case of cervical disc disease. Imaging studies are not required to make the diagnosis of IVDS.

10A. Does the Veteran have IVDS of the cervical spine?

- Yes No

SECTION X - INTERVERTEBRAL DISC SYNDROME (IVDS) AND EPISODES REQUIRING BED REST (continued)

10B. If yes to question 10A above, has the Veteran had any episodes of acute signs and symptoms due to IVDS that required bed rest prescribed by a physician and treatment by a physician in the past 12 months?

Yes No

If yes select the total duration over the past 12 months:

- With no episodes of bed rest during the past 12 months
- With episodes of bed rest having a total duration of at least 1 week but less than 2 weeks during the past 12 months
- With episodes of bed rest having a total duration of at least 2 weeks but less than 4 weeks during the past 12 months
- With episodes of bed rest having a total duration of at least 4 weeks but less than 6 weeks during the past 12 months
- With episodes of bed rest having a total duration of at least 6 weeks during the past 12 months

10C. If yes to question 10B above, provide the following documentation that supports the yes response:

Medical history as described by the Veteran only, without documentation:

Medical history as shown and documented in the Veteran's file:

Individual date(s) of each treatment record(s) reviewed:

Facility/provider:

Describe treatment:

Other, describe:

SECTION XI - ASSISTIVE DEVICES

11A. 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):

- | | | | | |
|---------------------------------------|-------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Wheelchair | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Brace | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Crutches | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Cane | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Walker | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Other: _____ | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |

11B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

Remark 12.

SECTION XII - 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.

12A. Due to the Veteran's cervical spine 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 upper Left upper 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):

SECTION XIII - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

13A. 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):

Remark 12.

13B. 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?

- Yes No

If yes, complete appropriate dermatological questionnaire.

13C. Comments, if any:

Remark 12.

SECTION XIV - DIAGNOSTIC TESTING

Note: The diagnosis of degenerative arthritis (osteoarthritis) or post 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.

Imaging studies are not required to make the diagnosis of IVDS. Electromyography (EMG) studies are rarely required to diagnose radiculopathy in the appropriate clinical setting.

14A. Have imaging studies of the cervical spine been performed in conjunction with this examination?

- Yes No

14B. If yes, is degenerative or post traumatic arthritis documented?

- Yes No

14C. If yes, provide type of test or procedure, date and results (brief summary):

Remark 13.

Remark 3. Diagnosis

~~The dates of diagnosis on this DBQ may differ from those found elsewhere, especially in C&P exams. The VA provides clear and unambiguous direction on this matter in a note on all of its DBQs: "Date of diagnosis can be. . . **AN APPROXIMATE DATE DETERMINED THROUGH RECORD REVIEW OR REPORTED HISTORY.**" It is common practice for C&P examiners to disregard this guidance along with the reported history from the Veteran. Instead, they often record the date when a medical record first contains a diagnosis despite no requirement whatsoever from the VA to have such a correspondence on the DBQs. In contrast, I have completed a careful record review and medical history to determine the approximate date of some observable sign or symptom that was the first manifestation of a disability. This date most accurately reflects the beginning of impairment. It often long precedes the date in a medical record, sometimes by many years. There are no additional diagnoses.~~

Remark 4. Medical history

See associated medical opinion for medical history.

Flare-ups: "Flare-ups interfere with all of my work and activities of daily living."

Repeated use over time: "Repeated use over time results in increased symptoms which interfere with walking, standing, lifting, reaching, and carrying."

Remark 5. Functional loss

Loss of ROM limits the ability to function normally because it degrades the operation of skeletal joints in all domains of normally expected capability in an occupational environment.

Remark 6. Active & Passive ROM

ACTIVE ROM: joint movements were measured in the sitting position against strong manual resistance from the examiner's hands. This loaded the joints to best simulate actual function in a physically demanding, non-sedentary occupational environment. This also measured ROM under "**WEIGHT-BEARING**" conditions which is most sensibly done during examination of active ROM.

PASSIVE ROM: joint movements were measured only against the resistance of gravity - that is, without any manual resistance from the examiner's hands. This unloaded the joints to the maximum practical extent to best simulate function in a lighter-duty, sedentary occupational environment. This also measured ROM under "**NONWEIGHT-BEARING**" conditions which is most sensibly done during examination of passive ROM.

The proper examination of joint ROM is addressed further in an additional appendix.

Remark 7. Evidence of pain

ROM was limited by pain. Loss of ROM limits the ability to function normally because it degrades the operation of skeletal joints in all domains of normally expected capability in an occupational environment. Crepitus in the cervical spine is due to the claimed condition. The cervical spine and associated soft tissues were moderately tender due to the claimed condition.

Remark 8. Estimated ROM after repeated use over time and during flare-ups

The estimated ROM was based on all procurable evidence including my medical expertise as well as a thorough medical history incorporating lay statements from the Veteran.

Remark 9. Guarding and additional factors contributing to disability

The cervical spine and associated soft tissues are moderately tender due to the claimed condition. Muscle spasms and guarding are present in the cervical spine and associated soft tissues and cause abnormal gait and contour due to the claimed condition. The selected factors contribute to disability by interfering with the normal mechanical functions of the body which then leads to difficulty with the basic activities of daily living.

Remark 10. Sensory findings

Upper extremities:	Right:	Left:
Vibratory sense (tuning fork):	Decreased.	Normal.
Cold sense (side of tuning fork):	Decreased.	Normal.
Soft sense (brush):	Decreased.	Normal.
Sharp sense (pin):	Decreased.	Normal.
Proprioception sense (position):	Decreased.	Normal.

Remark 11. Radiculopathy

Not applicable.

Remark 12. Assistive devices, other findings, and scars

Not applicable.

Remark 13. Diagnostic testing

X-ray study normal. Report enclosed.

Remark 14. Functional impact

All occupational tasks (sedentary and non-sedentary) are impacted due to interference with walking, standing, lifting, reaching, and carrying, and due to distraction and lack of concentration from chronic pain.

Remark 15. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily~~

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN HAVE A PERIPHERAL NERVE CONDITION OR PERIPHERAL NEUROPATHY?

Yes No *(If "Yes," complete Item 1B)*

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO A PERIPHERAL NERVE CONDITION AND/OR PERIPHERAL NEUROPATHY:

Diagnosis # 1: Left leg Remark 3.	ICD Code: Remark 3.	Date of diagnosis: Remark 3.
Diagnosis # 2: Right arm Remark 3.	ICD Code: Remark 3.	Date of diagnosis: Remark 3.
Diagnosis # 3:	ICD Code:	Date of diagnosis:

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO A PERIPHERAL NERVE CONDITION AND/OR PERIPHERAL NEUROPATHY, LIST USING ABOVE FORMAT:

Remark 3.

DEFINITIONS: For VA purposes, neuralgia indicates a condition characterized by a dull and intermittent pain of typical distribution so as to identify the nerve, while neuritis is characterized by loss of reflexes, muscle atrophy, sensory disturbances and constant pain, at times excruciating.

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S PERIPHERAL NERVE CONDITION *(brief summary)*:

Remark 4.

2B. DOMINANT HAND

Right Left Ambidextrous

SECTION III - SYMPTOMS

3A. Does the Veteran have any symptoms attributable to any peripheral nerve conditions?

Yes No

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

Constant pain *(may be excruciating at times)*

Right upper extremity:	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left upper extremity:	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Right lower extremity:	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input checked="" type="checkbox"/> Moderate	<input type="checkbox"/> Severe

Intermittent pain *(usually dull)*

Right upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input checked="" type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left upper extremity:	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Right lower extremity:	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input checked="" type="checkbox"/> Severe

Paresthesias and/or dysesthesias

Right upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input checked="" type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left upper extremity:	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Right lower extremity:	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input checked="" type="checkbox"/> Severe

SECTION III - SYMPTOMS (Continued)

3A. Does the veteran have any symptoms attributable to any peripheral nerve conditions? (Continued)

Numbness

Right upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input checked="" type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left upper extremity:	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Right lower extremity:	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input checked="" type="checkbox"/> Severe

3B. Other symptoms (describe symptoms, location and severity):

Remark 5.

SECTION IV - MUSCLE STRENGTH TESTING

4A. 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

All normal

Elbow flexion:	Right:	<input checked="" type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input checked="" type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Elbow extension:	Right:	<input checked="" type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input checked="" type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Wrist flexion:	Right:	<input checked="" type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input checked="" type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Wrist extension:	Right:	<input type="checkbox"/> 5/5	<input checked="" type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input checked="" type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Grip:	Right:	<input type="checkbox"/> 5/5	<input checked="" type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input checked="" type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Pinch (thumb to index finger):	Right:	<input checked="" type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input checked="" type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Knee extension:	Right:	<input checked="" type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input checked="" type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Ankle plantar flexion:	Right:	<input checked="" type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input checked="" type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Ankle dorsiflexion:	Right:	<input checked="" type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input checked="" type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5

4B. Does the veteran have muscle atrophy?

Yes No

If muscle atrophy is present, indicate location: Remark 6.

For each instance of muscle atrophy, provide measurements in centimeters of normal side and atrophied side, measured at maximum muscle bulk:

Normal side:	cm	Atrophied side:	cm
--------------	----	-----------------	----

SECTION V - REFLEX EXAM

5. Rate deep tendon reflexes (DTRs) according to the following scale:

- 0 Absent
- 1+ Hypoactive
- 2+ Normal
- 3+ Hyperactive without clonus
- 4+ Hyperactive with clonus

All normal

Biceps	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input checked="" type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input checked="" type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Triceps	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input checked="" type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input checked="" type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Brachioradialis	Right:	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Knee	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input checked="" type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Ankle	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input checked="" type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+

SECTION VI - SENSORY EXAM

6. Indicate results for sensation testing for light touch:

All normal

Shoulder area (C5):	Right:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Inner/outer forearm (C6/T1):	Right:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Hand/fingers (C6-8):	Right:	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Upper anterior thigh (L2):	Right:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Thigh/knee (L3/4):	Right:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Lower leg/ankle (L4/L5/S1):	Right:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Foot/toes (L5):	Right:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Decreased	<input type="checkbox"/> Absent

Other sensory findings, if any:

Remark 7.

SECTION VII - TROPHIC CHANGES

7. DOES THE VETERAN HAVE TROPHIC CHANGES (*characterized by loss of extremity hair, smooth, shiny skin, etc.*) ATTRIBUTABLE TO PERIPHERAL NEUROPATHY?

Yes No

If yes, describe:

Remark 8.

SECTION VIII - GAIT

8. IS THE VETERAN'S GAIT NORMAL?

Yes No

If no, describe abnormal gait:

Remark 9.

Provide etiology of abnormal gait:

Remark 9.

SECTION IX - SPECIAL TESTS FOR MEDIAN NERVE

9. WERE SPECIAL TESTS INDICATED AND PERFORMED FOR MEDIAN NERVE EVALUATION?

Yes No

If yes, indicate results:

Phalen's sign:	Right:	<input type="checkbox"/> Positive	<input checked="" type="checkbox"/> Negative
	Left:	<input type="checkbox"/> Positive	<input checked="" type="checkbox"/> Negative
Tinel's sign:	Right:	<input type="checkbox"/> Positive	<input checked="" type="checkbox"/> Negative
	Left:	<input type="checkbox"/> Positive	<input checked="" type="checkbox"/> Negative

SECTION X - NERVES AFFECTED: Severity Evaluation for Upper Extremity Nerves and Radicular Groups

Based on symptoms and findings from this exam, complete the following section to provide an estimation of the severity of the veteran's peripheral neuropathy. This summary provides useful information for VA purposes.

NOTE: For VA purposes, the term "incomplete paralysis" indicates a degree of lost or impaired function substantially less than the description of complete paralysis that is given with each nerve.

If the nerve is completely paralyzed, check the box for "complete paralysis." If the nerve is not completely paralyzed, check the box for "incomplete paralysis" and indicate severity. For VA purposes, when nerve impairment is wholly sensory, the evaluation should be mild, or at most, moderate.

SECTION X - NERVES AFFECTED: Severity Evaluation for Upper Extremity Nerves and Radicular Groups (Continued)**NOTE:** INDICATE THE AFFECTED NERVES, SIDE AFFECTED AND SEVERITY OF CONDITION.10A. Radial nerve (*musculospiral nerve*)Note: Complete paralysis (*hand and fingers drop, wrist and fingers flexed; cannot extend hand at wrist, extend proximal phalanges of fingers, extend thumb or make lateral movement of wrist; supination of hand, elbow extension and flexion weak, hand grip impaired*)Right: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

 Mild Moderate SevereLeft: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

 Mild Moderate Severe

10B. Median nerve

Note: Complete paralysis (*hand inclined to the ulnar side, index and middle fingers extended, atrophy of thenar eminence, cannot make fist, defective opposition of thumb, cannot flex distal phalanx of thumb; wrist flexion weak*)Right: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

 Mild Moderate SevereLeft: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

 Mild Moderate Severe

10C. Ulnar nerve

Note: Complete paralysis (*"griffin claw" deformity, atrophy in dorsal interspaces, thenar and hypothenar eminences; cannot extend ring and little finger, cannot spread fingers, cannot adduct the thumb; wrist flexion weakened*)Right: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

 Mild Moderate SevereLeft: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

 Mild Moderate Severe

10D. Musculocutaneous nerve

Note: Complete paralysis (*weakened flexion of elbow and supination of forearm*)Right: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

 Mild Moderate SevereLeft: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

 Mild Moderate Severe

10E. Circumflex nerve

Note: Complete paralysis (*innervates deltoid and teres minor; cannot abduct arm, outward rotation is weakened*)Right: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

 Mild Moderate SevereLeft: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

 Mild Moderate Severe

10F. Long thoracic nerve

Note: Complete paralysis (*inability to raise arm above shoulder level, winged scapula deformity*)Right: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

 Mild Moderate SevereLeft: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

 Mild Moderate Severe

SECTION X - NERVES AFFECTED: Severity Evaluation for Upper Extremity Nerves and Radicular Groups (Continued)

10G. Upper radicular group (5th & 6th cervicals)

Note: Complete paralysis (*all shoulder and elbow movements lost; hand and wrist movements not affected*)

Right: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

Mild Moderate Severe

Left: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

Mild Moderate Severe

10H. Middle radicular group

Note: Complete paralysis (*adduction, abduction, rotation of arm, flexion of elbow and extension of wrist lost*)

Right: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

Mild Moderate Severe

Left: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

Mild Moderate Severe

10I. Lower radicular group

Note: Complete paralysis (*intrinsic hand muscles, wrist and finger flexors paralyzed; substantial loss of use of hand*)

Right: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

Mild Moderate Severe

Left: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

Mild Moderate Severe

SECTION XI - NERVES AFFECTED: Severity Evaluation for Lower Extremity Nerves

Based on symptoms and findings from this exam, complete the following section to provide an estimation of the severity of the veteran's peripheral neuropathy. This summary provides useful information for VA purposes.

NOTE: For VA purposes, the term "incomplete paralysis" indicates a degree of lost or impaired function substantially less than the description of complete paralysis that is given with each nerve.

If the nerve is completely paralyzed, check the box for "complete paralysis." If the nerve is not completely paralyzed, check the box for "incomplete paralysis" and indicate severity. For VA purposes, when nerve impairment is wholly sensory, the evaluation should be mild, or at most, moderate.

NOTE: INDICATE AFFECTED NERVES, SIDE AFFECTED AND SEVERITY OF CONDITION.

11A. Sciatic nerve

Note: Complete paralysis (*foot dangles and drops, no active movement of muscles below the knee, flexion of knee weakened or lost*)

Right: Normal Incomplete paralysis Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild Moderate Moderately Severe Severe, with marked muscular atrophy

Left: Normal Incomplete paralysis Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild Moderate Moderately Severe Severe, with marked muscular atrophy

11B. External popliteal (*common peroneal*) nerve

Note: Complete paralysis (*foot drop, cannot dorsiflex foot or extend toes; dorsum of foot and toes are numb*)

Right: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

Mild Moderate Severe

Left: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

Mild Moderate Severe

11C. Musculocutaneous (*superficial peroneal*) nerve

Note: Complete paralysis (*everision of foot weakened*)

Right: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

Mild Moderate Severe

SECTION XI - NERVES AFFECTED: Severity Evaluation for Lower Extremity Nerves (Continued)

11C. Musculocutaneous (*superficial peroneal*) nerve (*continued*)

Left: Normal Incomplete paralysis Complete paralysis
 If Incomplete paralysis is checked, indicate severity:
 Mild Moderate Severe

11D. Anterior tibial (*deep peroneal*) nerve

Note: Complete paralysis (*dorsiflexion of foot lost*)

Right: Normal Incomplete paralysis Complete paralysis
 If Incomplete paralysis is checked, indicate severity:
 Mild Moderate Severe

Left: Normal Incomplete paralysis Complete paralysis
 If Incomplete paralysis is checked, indicate severity:
 Mild Moderate Severe

11E. Internal popliteal (*tibial*) nerve

Note: Complete paralysis (*plantar flexion lost, frank adduction of foot impossible, flexion and separation of toes abolished; no muscle in sole can move; in lesions of the nerve high in popliteal fossa, plantar flexion of foot is lost*)

Right: Normal Incomplete paralysis Complete paralysis
 If Incomplete paralysis is checked, indicate severity:
 Mild Moderate Severe

Left: Normal Incomplete paralysis Complete paralysis
 If Incomplete paralysis is checked, indicate severity:
 Mild Moderate Severe

11F. Posterior tibial nerve

Note: Complete paralysis (*paralysis of all muscles of sole of foot, frequently with painful paralysis of a causalgic nature; loss of toe flexion; adduction weakened; plantar flexion impaired*)

Right: Normal Incomplete paralysis Complete paralysis
 If Incomplete paralysis is checked, indicate severity:
 Mild Moderate Severe

Left: Normal Incomplete paralysis Complete paralysis
 If Incomplete paralysis is checked, indicate severity:
 Mild Moderate Severe

11G. Anterior crural (*femoral*) nerve

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

Right: Normal Incomplete paralysis Complete paralysis
 If Incomplete paralysis is checked, indicate severity:
 Mild Moderate Severe

Left: Normal Incomplete paralysis Complete paralysis
 If Incomplete paralysis is checked, indicate severity:
 Mild Moderate Severe

11H. Internal saphenous nerve

Right: Normal Incomplete paralysis Complete paralysis
 If Incomplete paralysis is checked, indicate severity:
 Mild Moderate Severe

Left: Normal Incomplete paralysis Complete paralysis
 If Incomplete paralysis is checked, indicate severity:
 Mild Moderate Severe

11I. Obturator nerve

Right: Normal Incomplete paralysis Complete paralysis
 If Incomplete paralysis is checked, indicate severity:
 Mild Moderate Severe

Left: Normal Incomplete paralysis Complete paralysis
 If Incomplete paralysis is checked, indicate severity:
 Mild Moderate Severe

SECTION XI - NERVES AFFECTED: Severity Evaluation for Lower Extremity Nerves (Continued)

11J. External cutaneous nerve of the thigh

Right: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

Mild Moderate Severe

Left: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

Mild Moderate Severe

11K. Ilio inguinal nerve

Right: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

Mild Moderate Severe

Left: Normal Incomplete paralysis Complete paralysis

If Incomplete paralysis is checked, indicate severity:

Mild Moderate Severe

SECTION XII - ASSISTIVE DEVICES

12A. 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 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

12B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

Remark 10.

SECTION XIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

13. Due to peripheral nerve 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 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):

SECTION XIV - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

14A. 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):

Remark 11.

SECTION XIV - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS (Continued)

14B. 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?

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: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

14C. COMMENTS, IF ANY:

Remark 12.

SECTION XV - DIAGNOSTIC TESTING

NOTE: For the purpose of this examination, electromyography (EMG) studies are usually rarely required to diagnose specific peripheral nerve conditions in the appropriate clinical setting. If EMG studies are in the medical record and reflect the veteran's current condition, repeat studies are not indicated.

15A. HAVE EMG STUDIES BEEN PERFORMED?

Yes No

Extremities tested:

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

If abnormal, describe: Remark 13.

15B. 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*):

Remark 14.

Remark 3. Diagnosis

Diagnosis # 1: Left leg sciatic radiculopathy; ICD Code: M54.32 ; Date of diagnosis: 2000.

Diagnosis # 1: Right arm ulnar neuropathy; ICD Code: M79.2; Date of diagnosis: 2019.

~~The dates of diagnosis on this DBQ may differ from those found elsewhere, especially in C&P exams. The VA provides clear and unambiguous direction on this matter in a note on all of its DBQs: "Date of diagnosis can be. . . **AN APPROXIMATE DATE DETERMINED THROUGH RECORD REVIEW OR REPORTED HISTORY.**" It is common practice for C&P examiners to disregard this guidance along with the reported history from the Veteran. Instead, they often record the date when a medical record first contains a diagnosis despite no requirement whatsoever from the VA to have such a correspondence on the DBQs. In contrast, I have completed a careful record review and medical history to determine the approximate date of some observable sign or symptom that was the first manifestation of a disability. This date most accurately reflects the beginning of impairment. It often long precedes the date in a medical record, sometimes by many years. There are no additional diagnoses.~~

Remark 4. Medical history

See associated medical opinion for medical history.

Remark 5. Symptoms

No other symptoms.

Remark 6. Muscle atrophy

Not applicable.

Remark 7. Other sensory findings

Upper extremities:	Right:	Left:
Vibratory sense (tuning fork):	Decreased.	Normal.
Cold sense (side of tuning fork):	Decreased.	Normal.
Soft sense (brush):	Decreased.	Normal.
Sharp sense (pin):	Decreased.	Normal.
Proprioception sense (position):	Decreased.	Normal.

Lower extremities:	Right:	Left:
Vibratory sense (tuning fork):	Normal.	Decreased.
Cold sense (side of tuning fork):	Normal.	Decreased.
Soft sense (brush):	Normal.	Decreased.
Sharp sense (pin):	Normal.	Decreased.
Proprioception sense (position):	Normal.	Decreased.

Remark 8. Trophic changes

Trophic changes present in the right upper extremity and left lower extremity with loss of extremity hair and smooth, shiny skin.

Remark 9. Gait

Gait is antalgic due to the left sciatic condition and multiple musculoskeletal conditions.

Remark 10. Assistive devices

Not applicable.

Remark 11. Other findings

Not applicable.

Remark 12. Scars

Not applicable.

Remark 13. Diagnostic testing

Not applicable.

Remark 14. Other diagnostic test findings

Not applicable.

Remark 15. Functional impact

All occupational tasks (sedentary and non-sedentary) are impacted due to distraction and lack of concentration from chronic pain, a moderate reduction in fingering and feeling of items, and typing with the right hand, and moderate impairment of walking, standing, lifting, and carrying due to the left leg.

Remark 16. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective – that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to~~

Name of Claimant/Veteran

Claimant/Veteran's Social Security Number

Date of Examination

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

Remark 1.

 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?

Remark 1.

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.

Remark 2.

SECTION I - DIAGNOSIS

1A. List the claimed condition(s) that pertain to this questionnaire:

Foot condition.

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, explain your findings and reasons in comments 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.

SECTION I - DIAGNOSIS (continued)

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 comments section.)

Note: If any condition is checked below, complete all of Section 1, Section 2, and also the applicable Section(s) 3 through 11 with which the condition is most associated.

Diagnosis:	Side affected:	ICD Code:	Date of diagnosis:
<input type="checkbox"/> Flat foot (pes planus)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input checked="" type="checkbox"/> Plantar fasciitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Both	M72.2	Right: 2012 Left: 2012
<input type="checkbox"/> Morton's neuroma	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Metatarsalgia	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Hammer toes	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Hallux valgus	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Hallux rigidus	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Acquired pes cavus (claw foot)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Malunion/nonunion of tarsal/ metatarsal bones	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Foot injury(ies), specify:	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
 <input type="checkbox"/> Arthritic conditions:			
<input type="checkbox"/> Arthritis, degenerative, other than post traumatic	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, gonorrheal	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, pneumococcic	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, streptococcic	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, syphilitic	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, multi joint (except post traumatic and gout), as an active process	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, post traumatic	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, typhoid	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, other specified forms of arthropathy (excluding gout)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
 <input type="checkbox"/> Inflammatory conditions:			
<input type="checkbox"/> Osteoporosis, residuals of	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Osteomalacia, residuals of	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Bones, neoplasm, benign	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Bones, neoplasm, malignant, primary or secondary	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Osteitis deformans	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Gout	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Myositis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Myositis ossificans	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Other specified forms:	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
 <input type="checkbox"/> Tendinopathy (select one if known)			
<input type="checkbox"/> Tendinitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Tendinosis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Tenosynovitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
 <input type="checkbox"/> Other, specify:			
<input type="checkbox"/> Diagnosis #1	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Diagnosis #2	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Diagnosis #3	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____

SECTION I - DIAGNOSIS (continued)

1C. If there are additional diagnoses that pertain to foot conditions, list using above format:

Remark 3.

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's foot condition (brief summary):

Remark 4.

2B. Does the Veteran report pain of the foot being evaluated on this questionnaire?

Yes No

If yes, document the Veteran's description of pain in his or her own words:

Remark 4.

2C. Does the Veteran report that flare ups impact the function of the foot?

Yes No

If so, ask the Veteran to describe 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.

Remark 4.

2D. 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 repeated use over time?

Yes No

If yes, document the Veteran's description of functional loss or functional impairment in his/her own words:

Remark 4.

SECTION III - FLATFOOT (PES PLANUS)

Note: Indicate all signs and symptoms that apply to the Veteran's flatfoot (pes planus) condition, regardless of whether similar signs and symptoms appear more than once in different sections.

3A. 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

3B. 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

SECTION III - FLATFOOT (PES PLANUS) (continued)

3C. Is there indication of swelling on use?

Yes No

If yes, indicate side affected:

Right Left Both

3D. Does the Veteran have characteristic calluses?

Yes No

If yes, indicate side affected:

Right Left Both

3E. Effects of use of arch supports or built up shoes

Effecting Complete Relief of Symptoms		Tried But Remains Symptomatic	
Device	Side Relieved	Device	Side Not Relieved
<input type="checkbox"/> Arch Supports	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Arch Supports	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Built up Shoes	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Built up Shoes	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both

3F. Does the Veteran have extreme tenderness of plantar surfaces on one or both feet?

Yes No

If yes, indicate side affected:

Right Left Both

Is the tenderness improved by orthopedic shoes or appliances?

Right Yes No N/A

Left Yes No N/A

3G. Does the Veteran have decreased longitudinal arch height of one or both feet on weight bearing?

Yes No

If yes, indicate side affected:

Right Left Both

3H. Is there objective evidence of marked deformity of one or both feet (pronation, abduction, etc.)?

Yes No

If yes, indicate side affected:

Right Left Both

3I. Is there marked pronation of one foot or both feet?

Yes No

If yes, indicate side affected:

Right Left Both

Is the condition improved by orthopedic shoes or appliances?

Right Yes No N/A

Left Yes No N/A

SECTION III - FLATFOOT (PES PLANUS) (continued)

3J. For one or both feet, is the weight bearing line over or medial to the great toe?

Yes No

If yes, indicate side affected:

Right Left Both

3K. 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:

3L. Does the Veteran have "inward" bowing of the Achilles' tendon (i.e., hindfoot valgus, with lateral deviation of the heel) of one or both feet?

Yes No

If yes, indicate side affected:

Right Left Both

3M. Does the Veteran have marked inward displacement and severe spasm of the Achilles' tendon (rigid hindfoot) on manipulation of one or both feet?

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?

Right Yes No N/A

Left Yes No N/A

3N. Comments, if any:

Remark 5.

SECTION IV - PLANTAR FASCIITIS

4A. Has the Veteran undergone non surgical treatment for plantar fasciitis?

Yes No

If yes, indicate side:

Right Left Both

4B. If yes, did the non surgical treatment relieve the symptoms?

Yes No

If no, indicate side not relieved:

Right Left Both

SECTION IV - PLANTAR FASCIITIS (continued)

4C. Has the Veteran undergone surgical treatment for plantar fasciitis?

Yes No (if no, proceed to 4E)

If yes, indicate side:

Right Left Both

4D. If yes, did the surgical treatment relieve the symptoms?

Yes No

If no, indicate side not relieved:

Right Left Both

4E. If the Veteran has not undergone surgical treatment, was the Veteran recommended for surgical intervention, but was not a surgical candidate?

Yes No

If yes, indicate side:

Right Left Both

4F. Does the Veteran have any functional loss of the foot/feet due to plantar fasciitis?

Yes No

If yes, indicate side affected:

Right Left Both

Describe the functional loss of the foot/feet due to plantar fasciitis:

Remark 6.

4G. Comments, if any:

Remark 6.

SECTION V - MORTON'S NEUROMA (MORTON'S DISEASE) AND METATARSALGIA

5A. Does the Veteran have Morton's neuroma?

Yes No

If yes, indicate side affected:

Right Left Both

5B. Does the Veteran have metatarsalgia?

Yes No

If yes, indicate side affected:

Right Left Both

SECTION V - MORTON'S NEUROMA (MORTON'S DISEASE) AND METATARSALGIA (continued)

5C. Comments, if any:

Remark 7.

SECTION VI - HAMMER TOE

6A. If the Veteran has hammer toes, which toes are affected?

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

6B. Comments, if any:

SECTION VII - HALLUX VALGUS

7A. 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

7B. Has the Veteran had surgery for hallux valgus?

Yes No

If yes, indicate type and date of surgery and side affected:

Resection of metatarsal head

Date of surgery: _____ Side affected: Right Left Both

Tarsal 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

7C. Comments, if any:

Remark 8.

SECTION VIII - HALLUX RIGIDUS

8A. 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

8B. Comments, if any:

Remark 9.

SECTION IX - ACQUIRED PES CAVUS (CLAW FOOT)

9A. Effect on toes due to pes cavus (check all that apply):

- | | | | |
|---|--------------------------------|-------------------------------|-------------------------------|
| <input checked="" type="checkbox"/> None | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Great toe dorsiflexed | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> All toes tending to dorsiflexion | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> All toes hammer toes | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, describe (if there is an effect on toes due to etiology other than pes cavus, indicate other etiology): | | | |

9B. Pain and tenderness due to pes cavus (check all that apply):

- | | | | |
|--|--------------------------------|-------------------------------|-------------------------------|
| <input checked="" type="checkbox"/> None | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Definite tenderness under metatarsal heads | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Marked tenderness under metatarsal heads | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Very painful callosities | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, describe (if the Veteran has pain and tenderness due to etiology other than pes cavus, indicate other etiology): | | | |

9C. Effect on plantar fascia due to pes cavus (check all that apply):

- | | | | |
|---|--------------------------------|-------------------------------|-------------------------------|
| <input checked="" type="checkbox"/> None | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Shortened plantar fascia | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Marked contraction of plantar fascia with dropped forefoot | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, describe (if there is an effect on plantar fascia due to etiology other than pes cavus, indicate other etiology): | | | |

SECTION IX - ACQUIRED PES CAVUS (CLAW FOOT) (continued)

9D. Dorsiflexion and varus deformity due to pes cavus (check all that apply):

- | | | | |
|---|--------------------------------|-------------------------------|-------------------------------|
| <input checked="" type="checkbox"/> None | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Some limitation of dorsiflexion at ankle | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Limitation of dorsiflexion at ankle to right angle | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Marked varus deformity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, describe (if the Veteran has dorsiflexion and varus deformity due to etiology other than pes cavus, indicate other etiology): | | | |

9E. Comments, if any:

SECTION X - MALUNION OR NONUNION OF TARSAL OR METATARSAL BONES

10A. Indicate severity and side affected for malunion or nonunion of tarsal or metatarsal bones:

- | | | | |
|--|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Moderately severe | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Severe | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

10B. Comments, if any:

SECTION XI - FOOT INJURIES AND OTHER CONDITIONS

Note: Complete this section if the Veteran has any foot injuries or other foot conditions listed in Section 1B not already described above in Sections 3 through 10.

Note: For VA purposes "bilateral weak foot" describes a symptomatic condition secondary to many constitutional conditions, and is characterized by atrophy of the musculature, disturbed circulation and weakness.

11A. Does the Veteran have any foot injuries or other foot conditions not already described?

- Yes No

If yes, describe the foot injury or other foot conditions (including frequency and physical exam findings) and complete question 11B (severity and side affected).

Remark 10.

11B. Indicate severity and side affected.

- | | | | |
|--|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Not affected | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Moderately severe | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Severe | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

SECTION XI - FOOT INJURIES AND OTHER CONDITIONS (continued)

11C. Does the foot condition chronically compromise weight bearing?

Yes No

11D. Does the foot condition require arch supports, custom orthotic inserts or shoe modifications?

Yes No

11E. Comments, if any:

Remark 10.

SECTION XII - SURGICAL PROCEDURES

Note: Complete this section if the Veteran has had any surgical procedures for the claimed condition that have not already been described.

12A. Has the Veteran had foot surgery (arthroscopic or open)?

Yes No

If yes, indicate side affected, type of procedure and date of surgery.

Right foot procedure: _____

Date of surgery: _____

Left foot procedure: _____

Date of surgery: _____

12B. Does the Veteran have any residual signs or symptoms due to arthroscopic or other foot surgery?

Yes No

If yes, describe residuals:

Remark 11.

SECTION XIII - PAIN

Foot	Is there pain on physical exam?	If no, but the Veteran reported pain in his/her medical history, please provide rationale below.	If yes (there is pain on physical exam), does the pain contribute to functional loss?	If no (i.e., the pain does not contribute to functional loss or additional limitations), explain why:
Right Foot	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	N/A	<input checked="" type="checkbox"/> Yes (you will be asked to further describe these limitations in Section 14) <input type="checkbox"/> No	N/A
Left Foot	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	N/A	<input checked="" type="checkbox"/> Yes (you will be asked to further describe these limitations in Section 14) <input type="checkbox"/> No	N/A

SECTION XIV - FUNCTIONAL LOSS

Note: VA defines functional loss as the inability, due to damage or infection in parts of the system, to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance. As regards the joints, factors of disability reside in reductions of their normal excursion of movements in different planes.

Using information 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), the examiner's medical expertise, and physical exam, select the factors below that contribute to functional loss or impairment (regardless of repetitive use) or to additional limitation of range of motion (ROM) after repetitive use for the joint or extremity being evaluated on this questionnaire:

14A. Contributing factors of disability (check all that apply and indicate side affected):

- | | | | |
|--|--------------------------------|-------------------------------|--|
| <input type="checkbox"/> No functional loss for <u>left</u> lower extremity attributable to claimed condition | | | |
| <input type="checkbox"/> No functional loss for <u>right</u> lower extremity attributable to claimed condition | | | |
| <input checked="" type="checkbox"/> Less movement than normal | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input checked="" type="checkbox"/> Both |
| <input type="checkbox"/> More movement than normal | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input checked="" type="checkbox"/> Weakened movement | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input checked="" type="checkbox"/> Both |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Deformity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Atrophy of disuse | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Instability of station | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input checked="" type="checkbox"/> Disturbance of locomotion | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input checked="" type="checkbox"/> Both |
| <input type="checkbox"/> Interference with sitting | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input checked="" type="checkbox"/> Interference with standing | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input checked="" type="checkbox"/> Both |
| <input checked="" type="checkbox"/> Pain | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input checked="" type="checkbox"/> Both |
| <input checked="" type="checkbox"/> Fatigue | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input checked="" type="checkbox"/> Both |
| <input checked="" type="checkbox"/> Weakness | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input checked="" type="checkbox"/> Both |
| <input checked="" type="checkbox"/> Lack of endurance | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input checked="" type="checkbox"/> Both |
| <input checked="" type="checkbox"/> Incoordination | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input checked="" type="checkbox"/> Both |
| <input type="checkbox"/> Other, describe: | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

14B. Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability during flare ups and/or after repeated use over time?

- Yes No

If yes, indicate side affected:

- Right Left Both

If yes (there is a functional loss due to pain, during flare ups and/or after repeated use over time), please describe the functional loss as well as cite and discuss evidence (must be specific to the case and based on all procurable evidence):

Remark 12.

SECTION XIV - FUNCTIONAL LOSS (continued)

14C. Is there any other functional loss during flare ups and/or after repeated use over time?

Yes No

If yes, indicate side affected:

Right Left Both

If yes, describe:

N/A

Note: For any joint condition, unless medically contraindicated, the examiner should address pain on both passive and active motion, and on both weight bearing and nonweight bearing. These factors must be assessed for the claimed foot and the contralateral foot (even if the contralateral foot is unclaimed). Specific joint range of motion measurements in degrees do not need to be documented.

14D. Is there evidence of pain on any of the following? (check all that apply)

<input checked="" type="checkbox"/> Passive motion	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input checked="" type="checkbox"/> Both
<input checked="" type="checkbox"/> Active motion	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input checked="" type="checkbox"/> Both
<input checked="" type="checkbox"/> Weight bearing	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input checked="" type="checkbox"/> Both
<input type="checkbox"/> Nonweight bearing	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> On rest/non movement	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both

If yes, describe:

Remark 12.

If unable to assess, a rationale is required (e.g., the foot is in a cast; the contralateral unclaimed foot is damaged; etc.):

N/A

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

15A. 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):

Remark 13.

15B. 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?

Yes No

If yes, complete appropriate dermatological questionnaire.

SECTION XVI - ASSISTIVE DEVICES

16A. Does the Veteran use any assistive devices (other than those identified above) 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):

- | | | | | |
|---------------------------------------|-------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Wheelchair | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Brace | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Crutches | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Cane | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Walker | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Other: _____ | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |

16B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition:

Remark 13.

SECTION XVII - 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.

17A. Due to the Veteran's foot 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 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):

SECTION XVIII - DIAGNOSTIC TESTING

Note: Testing listed below is not indicated for every condition. Plain or weight bearing foot x rays are not required to make the diagnosis of flatfoot. 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.

18A. Have imaging studies been performed in conjunction with this examination?

Yes No

18B. If yes, is degenerative or post traumatic arthritis documented?

Yes No

If yes, indicate foot:

Right Left Both

18C. If yes, provide type of test or procedure, date and results (brief summary):

Remark 14.

Remark 3. Diagnosis

~~The dates of diagnosis on this DBQ may differ from those found elsewhere, especially in C&P exams. The VA provides clear and unambiguous direction on this matter in a note on all of its DBQs: "Date of diagnosis can be. . . **AN APPROXIMATE DATE DETERMINED THROUGH RECORD REVIEW OR REPORTED HISTORY.**" It is common practice for C&P examiners to disregard this guidance along with the reported history from the Veteran. Instead, they often record the date when a medical record first contains a diagnosis despite no requirement whatsoever from the VA to have such a correspondence on the DBQs. In contrast, I have completed a careful record review and medical history to determine the approximate date of some observable sign or symptom that was the first manifestation of a disability. This date most accurately reflects the beginning of impairment. It often long precedes the date in a medical record, sometimes by many years. There are no additional diagnoses.~~

Remark 4. Medical history

See associated medical opinion for medical history.

Pain: "I have very sharp pain in my right foot with any weight-bearing activities."

Flare-ups: "Flare-ups interfere with all of my work and activities of daily living."

Repeated use over time: "Repeated use over time results in increased symptoms which interfere with walking, standing, kneeling, lifting, carrying, squatting, and stairs."

Remark 5. Pes planus

Not applicable.

Remark 6. Plantar fasciitis

Functional loss includes interference with weight-bearing. Condition is incompletely relieved with orthotics and shoe inserts.

Remark 7. Morton's neuroma and metatarsalgia

Not applicable.

Remark 8. Hallux valgus

Not applicable.

Remark 9. Hallux rigidus

Not applicable.

Remark 10. Foot injuries and other conditions

Not applicable.

Remark 11. Surgical procedures

Not applicable.

Remark 12. Functional ability during flare-ups and/or after repeated use over time

BILATERAL: The estimated significant decrease in functional ability / loss related to further limitations from pain, fatigability, weakness, lack of endurance, and incoordination for activities such as walking, standing, kneeling, lifting, carrying, squatting, and stairs, as well as all other domains of normally expected foot capability in an occupational environment. This estimate was based on all procurable evidence including my medical expertise as well as a thorough medical history incorporating lay statements from the Veteran. On exam, pain was present with passive motion, active motion, and weight-bearing. There was no pain present when nonweight-bearing. Active ROM was measured in the sitting position with foot motion against strong manual resistance from the examiner's hands. Passive ROM was also measured in the sitting position but only against the resistance of gravity.

Remark 13. Other findings, scars, and assistive devices

Not applicable.

Remark 14. Diagnostic testing

Not applicable.

Remark 15. Functional impact

BILATERAL: All occupational tasks (sedentary and non-sedentary) are impacted due to interference with walking, standing, kneeling, lifting, carrying, squatting, and stairs, and due to distraction and lack of concentration from chronic pain.

Remark 16. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective—that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report competent for the assignment of weight," then the VA becomes legally obligated and **MUST ATTEMPT TO OBTAIN SUCH CLARIFICATION** directly from the private physician who issued the report; otherwise the VA must "clearly and adequately explain why such clarification is unreasonable." (38 USC 5103A; Carter v. Shinseki 26 Vet. App. 534; Savage v. Shinseki 24 Vet.~~

Name of Claimant/Veteran: [REDACTED]	Claimant/Veteran's Social Security Number: [REDACTED]	Date of examination: [REDACTED]
---	--	--

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 Remark 1.

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? Remark 1.

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.

Remark 2.

DOMINANT HAND

Dominant hand: Right Left Ambidextrous

SECTION I - DIAGNOSIS

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

1A. List the claimed conditions that pertain to this questionnaire.

Elbow condition.

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, explain your findings and reasons in the comments section below. 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 condition listed above. (Explain your findings and reasons in the comments section)

	Side affected:	ICD Code:	Date of diagnosis:	
<input type="checkbox"/> Olecranon bursitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Tricep tendinitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input checked="" type="checkbox"/> Lateral epicondylitis	<input checked="" type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<u>M77.00</u>	Right: <u>2019.</u>	Left: _____
<input type="checkbox"/> Medial epicondylitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Instability (medial/posterolateral rotatory)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Dislocation, elbow	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Osteoarthritis, elbow	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____

SECTION I - DIAGNOSIS (continued)

	Side affected:	ICD Code:	Date of diagnosis	
	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Total elbow arthroplasty	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Ankylosis of elbow joint	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Degenerative arthritis, other than post-traumatic	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, gonorrheal	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, pneumococcal	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, streptococcal	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, syphilitic	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, rheumatoid (multi-joint)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, post-traumatic	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, typhoid	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Other specified forms of arthropathy (excluding gout) (specify)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Osteoporosis, residuals of	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Osteomalacia, residuals of	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Bones, neoplasm, benign	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Osteitis deformans	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Gout	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Myositis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Heterotopic ossification	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input checked="" type="checkbox"/> Tendinopathy (select one if known)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input checked="" type="checkbox"/> Tendinitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Both	<u>M67.824</u>	Right: <u>2019</u>	Left: <u>2022</u>
<input type="checkbox"/> Tendinosis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Tenosynovitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
Other diagnosis #1: _____	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____
Other diagnosis #2: _____	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____	Left: _____

If there are additional diagnoses that pertain to an elbow or forearm condition, please list using above format:

Remark 3.

1C. Comments, if any:

Remark 3.

Note: In all forearm injuries, if there are impaired finger movements due to tendon, muscle, or nerve injuries, also complete the appropriate additional questionnaire(s).

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's elbow and/or forearm condition (brief summary).

Remark 4.

2B. Does the Veteran report flare-ups of the elbow or forearm?

Yes No

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

Remark 4.

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 or her own words:

Remark 4.

SECTION II - MEDICAL HISTORY (continued)

2D. Are there complaints of painful motion on flexion and/or extension?

Yes No

If yes, check all that apply: Flexion Extension

If yes, is the complaint of painful motion related to the claimed condition(s) identified in the diagnosis section?

Yes No

If yes, please specify the condition(s) Right elbow condition.

If no, describe what it is attributed to:

2E. Are there complaints of painful motion on forearm supination and/or pronation?

Yes No

If yes, check all that apply: Forearm supination Forearm pronation

If yes, is the complaint of painful motion related to the claimed condition(s) identified in the diagnosis section?

Yes No

If yes, please specify the condition(s) Right elbow condition.

If no, describe what it is attributed to:

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 opened 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.

3A. Initial ROM measurements:

<p>Right elbow</p> <p><input type="checkbox"/> All Normal <input checked="" type="checkbox"/> Abnormal or outside of normal range <input type="checkbox"/> Unable to test <input type="checkbox"/> Not indicated</p> <p>If unable to test or not indicated, please explain:</p> <p>If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than an elbow condition, such as age, body habitus, neurologic disease), please describe:</p> <p>If abnormal, does the range of motion itself contribute to a functional loss? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:</p> <p>Remark 5.</p>	<p>Left elbow</p> <p><input type="checkbox"/> All Normal <input checked="" type="checkbox"/> Abnormal or outside of normal range <input type="checkbox"/> Unable to test <input type="checkbox"/> Not indicated</p> <p>If unable to test or not indicated, please explain:</p> <p>If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than an elbow condition, such as age, body habitus, neurologic disease), please describe:</p> <p>If abnormal, does the range of motion itself contribute to a functional loss? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:</p> <p>Remark 5.</p>
--	---

Note: For any joint condition, examiners should address pain on both passive and active motion, and on both weight-bearing and nonweight-bearing. Examiners should also test the contralateral joint (unless medically contraindicated). If testing cannot be performed, or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation must be given. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).

<p>Can testing be performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, provide an explanation:</p> <p>If this is the unclaimed joint, is it: <input type="checkbox"/> Damaged <input type="checkbox"/> Undamaged</p> <p>If undamaged, range of motion testing must be conducted.</p>	<p>Can testing be performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, provide an explanation:</p> <p>If this is the unclaimed joint, is it: <input type="checkbox"/> Damaged <input checked="" type="checkbox"/> Undamaged</p> <p>If undamaged, range of motion testing must be conducted.</p>
--	---

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

Right elbow

Active Range of Motion (ROM) -
Perform active range of motion and provide the ROM values:

<input type="checkbox"/>	Flexion endpoint (145 degrees)	<u>100</u>	degrees
<input type="checkbox"/>	Extension endpoint (0 degrees)	<u>45</u>	degrees
<input type="checkbox"/>	Forearm supination endpoint (85 degrees)	<u>70</u>	degrees
<input type="checkbox"/>	Forearm pronation endpoint (80 degrees)	<u>50</u>	degrees

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

<input checked="" type="checkbox"/>	Flexion	<input checked="" type="checkbox"/>	Forearm supination
<input checked="" type="checkbox"/>	Extension	<input checked="" type="checkbox"/>	Forearm pronation

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

<u>100</u>	Flexion degree endpoint (if different than above)
<u>45</u>	Extension degree endpoint (if different than above)
<u>75</u>	Forearm supination degree endpoint (if different than above)
<u>50</u>	Forearm pronation degree endpoint (if different than above)

Remark 6.

Left elbow

Active Range of Motion (ROM) -
Perform active range of motion and provide the ROM values:

<input type="checkbox"/>	Flexion endpoint (145 degrees)	<u>100</u>	degrees
<input type="checkbox"/>	Extension endpoint (0 degrees)	<u>45</u>	degrees
<input type="checkbox"/>	Forearm supination endpoint (85 degrees)	<u>70</u>	degrees
<input type="checkbox"/>	Forearm pronation endpoint (80 degrees)	<u>50</u>	degrees

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

<input checked="" type="checkbox"/>	Flexion	<input checked="" type="checkbox"/>	Forearm supination
<input checked="" type="checkbox"/>	Extension	<input checked="" type="checkbox"/>	Forearm pronation

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

<u>100</u>	Flexion degree endpoint (if different than above)
<u>45</u>	Extension degree endpoint (if different than above)
<u>75</u>	Forearm supination degree endpoint (if different than above)
<u>15</u>	Forearm pronation degree endpoint (if different than above)

Remark 6.

Passive range of motion -
Perform passive range of motion and provide ROM values:

Flexion endpoint (145 degrees):	<u>120</u> degrees	<input type="checkbox"/>	Same as active ROM
Extension endpoint (0 degrees):	<u>15</u> degrees	<input type="checkbox"/>	Same as active ROM
Forearm supination endpoint (85 degrees):	<u>80</u> degrees	<input type="checkbox"/>	Same as active ROM
Forearm pronation endpoint (80 degrees):	<u>65</u> degrees	<input type="checkbox"/>	Same as active ROM

If noted on examination, which passive ROM exhibited pain? (select all that apply):

<input checked="" type="checkbox"/>	Flexion	<input checked="" type="checkbox"/>	Forearm supination
<input checked="" type="checkbox"/>	Extension	<input checked="" type="checkbox"/>	Forearm pronation

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

<u>120</u>	Flexion degree endpoint (if different than above)
<u>15</u>	Extension degree endpoint (if different than above)
<u>80</u>	Forearm supination degree endpoint (if different than above)
<u>65</u>	Forearm pronation degree endpoint (if different than above)

Remark 6.

Passive range of motion -
Perform passive range of motion and provide ROM values:

Flexion endpoint (145 degrees):	<u>120</u> degrees	<input type="checkbox"/>	Same as active ROM
Extension endpoint (0 degrees):	<u>15</u> degrees	<input type="checkbox"/>	Same as active ROM
Forearm supination endpoint (85 degrees):	<u>80</u> degrees	<input type="checkbox"/>	Same as active ROM
Forearm pronation endpoint (80 degrees):	<u>65</u> degrees	<input type="checkbox"/>	Same as active ROM

If noted on examination, which passive ROM exhibited pain? (select all that apply):

<input checked="" type="checkbox"/>	Flexion	<input checked="" type="checkbox"/>	Forearm supination
<input checked="" type="checkbox"/>	Extension	<input checked="" type="checkbox"/>	Forearm pronation

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

<u>120</u>	Flexion degree endpoint (if different than above)
<u>15</u>	Extension degree endpoint (if different than above)
<u>80</u>	Forearm supination degree endpoint (if different than above)
<u>65</u>	Forearm pronation degree endpoint (if different than above)

Remark 6.

Is there evidence of pain? Yes No If yes, check all that apply:

<input checked="" type="checkbox"/>	Weight-bearing	<input checked="" type="checkbox"/>	Non-weightbearing
<input checked="" type="checkbox"/>	Active motion	<input checked="" type="checkbox"/>	Passive motion
<input type="checkbox"/>	On rest/non-movement	<input type="checkbox"/>	Does not result in/cause functional loss
<input checked="" type="checkbox"/>	Causes functional loss (if checked, describe below):		

Remark 7.

Is there evidence of pain? Yes No If yes, check all that apply:

<input checked="" type="checkbox"/>	Weight-bearing	<input checked="" type="checkbox"/>	Non-weightbearing
<input checked="" type="checkbox"/>	Active motion	<input checked="" type="checkbox"/>	Passive motion
<input type="checkbox"/>	On rest/non-movement	<input type="checkbox"/>	Does not result in/cause functional loss
<input checked="" type="checkbox"/>	Causes functional loss (if checked, describe below):		

Remark 7.

Is there objective evidence of crepitus? Yes No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?

Yes No

If yes, please explain. Include location, severity, and relationship to condition(s):

Remark 7.

Is there objective evidence of crepitus? Yes No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?

Yes No

If yes, please explain. Include location, severity, and relationship to condition(s):

Remark 7.

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

Right elbow	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:	Left elbow	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:
	Flexion endpoint (145 degrees): <u>100</u> degrees Extension endpoint (0 degrees): <u>45</u> degrees Forearm supination endpoint (85 degrees): <u>70</u> degrees Forearm pronation endpoint (80 degrees): <u>50</u> degrees		Flexion endpoint (145 degrees): <u>100</u> degrees Extension endpoint (0 degrees): <u>45</u> degrees Forearm supination endpoint (85 degrees): <u>70</u> degrees Forearm pronation endpoint (80 degrees): <u>50</u> degrees
	The examiner should provide the estimated range of motion 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.		The examiner should provide the estimated range of motion 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 here. (Must be specific to the case, and based on all procurable evidence.)		Please cite and discuss evidence here. (Must be specific to the case, and based on all procurable evidence.)
	Remark 8.		Remark 8.

3E. Additional factors contributing to disability:

Right elbow	In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:	Left elbow	In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:
	<input type="checkbox"/> None <input type="checkbox"/> Interference with standing <input type="checkbox"/> Disturbance of locomotion <input checked="" type="checkbox"/> Less movement than normal <input checked="" type="checkbox"/> Weakened movement <input type="checkbox"/> Instability of station		<input type="checkbox"/> None <input type="checkbox"/> Interference with standing <input type="checkbox"/> Disturbance of locomotion <input checked="" type="checkbox"/> Less movement than normal <input checked="" type="checkbox"/> Weakened movement <input type="checkbox"/> Instability of station
	<input type="checkbox"/> Interference with sitting <input type="checkbox"/> Swelling <input type="checkbox"/> Deformity <input type="checkbox"/> More movement than normal <input type="checkbox"/> Atrophy of disuse <input type="checkbox"/> Other, describe:		<input type="checkbox"/> Interference with sitting <input type="checkbox"/> Swelling <input type="checkbox"/> Deformity <input type="checkbox"/> More movement than normal <input type="checkbox"/> Atrophy of disuse <input type="checkbox"/> Other, describe:
	Please describe additional contributing factors of disability: Remark 9.		Please describe additional contributing factors of disability: Remark 9.

SECTION IV - MUSCLE ATROPHY

Right elbow	4A. Does the Veteran have muscle atrophy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Left elbow	4A. Does the Veteran have muscle atrophy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide rationale here:		4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide rationale here:
	4C. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk: <input type="checkbox"/> Right upper extremity: specify location of measurement such as "10cm above or below elbow": _____ Circumference of normal side: _____ cm Circumference of atrophied side: _____ cm		4C. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk: <input type="checkbox"/> Left upper extremity: specify location of measurement such as "10cm above or below elbow": _____ Circumference of normal side: _____ cm Circumference of atrophied side: _____ cm
	4D. Comments, if any:		4D. Comments, if any:

SECTION V- ANKYLOSIS

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

Right elbow

5A. Is there ankylosis of the elbow and/or forearm?

Yes No

If yes, indicate the severity of ankylosis:

- Favorable ankylosis, at an angle between 90 degrees and 70 degrees
- Intermediate ankylosis, at an angle of more than 90 degrees, or between 70 and 50 degrees
- Unfavorable ankylosis
 - At an angle of less than 50 degrees
 - With complete loss of supination
 - With complete loss of pronation

5B. Indicate angle of ankylosis in degrees: _____ degrees

Left elbow

5A. Is there ankylosis of the elbow and/or forearm?

Yes No

If yes, indicate the severity of ankylosis:

- Favorable ankylosis, at an angle between 90 degrees and 70 degrees
- Intermediate ankylosis, at an angle of more than 90 degrees, or between 70 and 50 degrees
- Unfavorable ankylosis
 - At an angle of less than 50 degrees
 - With complete loss of supination
 - With complete loss of pronation

5B. Indicate angle of ankylosis in degrees: _____ degrees

SECTION VI - OTHER IMPAIRMENTS

6A. Does the Veteran have flail joint, joint fracture, ununited fracture, malaligned fracture, or impairment of supination or pronation?

Yes No

If yes, indicate condition and complete the appropriate section(s) below:

- | | | | |
|--|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Flail joint | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Joint fracture | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> With marked cubitus varus deformity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> With marked cubitus valgus deformity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> With ununited fracture of head of radius | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Radius and ulna, nonunion of, with flail false joint | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Ulna, impairment of: | | | |
| <input type="checkbox"/> Nonunion in upper half with false movement: with loss of bone substance (1 inch (2.5 cm) or more) and marked deformity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Nonunion in upper half with false movement: without loss of bone substance or deformity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Nonunion in lower half | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Malunion of, with bad alignment | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Radius, impairment of | | | |
| <input type="checkbox"/> Nonunion in lower half, with false movement: with loss of bone substance (1 inch (2.5 cm) or more) and marked deformity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Nonunion in lower half, with false movement: without loss of bone substance or deformity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Nonunion in upper half | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Malunion of, with bad alignment | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Supination and pronation, impairment of | | | |
| <input type="checkbox"/> Loss of (bone fusion): hand fixed in supination | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Loss of (bone fusion): hand fixed in hyperpronation | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Loss of (bone fusion): hand fixed in full pronation | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Loss of (bone fusion): hand fixed near the middle of the arc: or moderate pronation | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Limitation of pronation: motion lost beyond the middle of the arc | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Limitation of pronation: motion lost beyond last quarter of arc; hand does not approach full pronation | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Limitation of supination: 30 degrees or less | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

6B. Comments, if any:

Remark 10.

SECTION VII - SURGICAL PROCEDURES

Right elbow

7A. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested. (check all that apply):

No surgery

Total elbow joint replacement:

Date of surgery: Remark 11.

Residuals:

- None
- Intermediate degrees of residual weakness, pain, or limitation of motion
- Chronic residuals consisting of severe painful motion or weakness
- Other, describe:

Remark 11.

Arthroscopic or other elbow surgery:

Type of surgery: Remark 11.

Date of surgery: Remark 11.

Describe residuals of arthroscopic or other surgery:

Remark 11.

Left elbow

7A. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested. (check all that apply):

No surgery

Total elbow joint replacement:

Date of surgery: Remark 11.

Residuals:

- None
- Intermediate degrees of residual weakness, pain, or limitation of motion
- Chronic residuals consisting of severe painful motion or weakness
- Other, describe:

Remark 11.

Arthroscopic or other elbow surgery:

Type of surgery: Remark 11.

Date of surgery: Remark 11.

Describe residuals of arthroscopic or other surgery:

Remark 11.

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

8A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs, and/or symptoms related to any of the conditions listed in the diagnosis section?

Yes No If yes, describe (brief summary):

Remark 12.

8B. Does the Veteran have any scars or other disfigurement of the skin related to any of the conditions, or to the treatment of any of the conditions, listed in the diagnosis section?

Yes No If yes, also complete the appropriate dermatological questionnaire.

8C. Comments, if any:

Remark 12.

SECTION IX - ASSISTIVE DEVICES

9A. 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: _____ Frequency of use: Occasional Regular Constant

9B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition:

Remark 12.

SECTION X - 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.

10A. Due to the Veteran's elbow and/or forearm 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.

- 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

10B. For each extremity checked, identify the condition causing loss of function, describe loss of effective function, and provide specific examples in a brief summary:

SECTION XI - 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.

11A. Have imaging studies been performed in conjunction with this examination? Yes No

11B. If yes, is degenerative or post-traumatic arthritis documented? Yes No

If yes, indicate side: Right Left Both

11C. If yes, provide type of test or procedure, date, and results (brief summary):

Remark 13.

11D. Are there any other significant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this exam?

Yes No

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

Remark 13.

11E. If any test results are other-than-normal, indicate relationship of abnormal findings to diagnosed conditions:

Remark 13.

SECTION XII - 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.

12A. Regardless of the Veteran's current employment status, do the condition(s) 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:

Remark 14.

SECTION XIII - REMARKS

13A. Remarks, if any:

Remark 15.

All remarks are in the first appendix.

Remark 3. Diagnosis

~~The dates of diagnosis on this DBQ may differ from those found elsewhere, especially in C&P exams. The VA provides clear and unambiguous direction on this matter in a note on all of its DBQs: "Date of diagnosis can be. . . **AN APPROXIMATE DATE DETERMINED THROUGH RECORD REVIEW OR REPORTED HISTORY.**" It is common practice for C&P examiners to disregard this guidance along with the reported history from the Veteran. Instead, they often record the date when a medical record first contains a diagnosis despite no requirement whatsoever from the VA to have such a correspondence on the DBQs. In contrast, I have completed a careful record review and medical history to determine the approximate date of some observable sign or symptom that was the first manifestation of a disability. This date most accurately reflects the beginning of impairment. It often long precedes the date in a medical record, sometimes by many years. There are no additional diagnoses.~~

Remark 4. Medical history

See associated medical opinion for medical history.

Flare-ups: "Flare-ups interfere with all of my work and activities of daily living."

Repeated use over time: "Repeated use over time results in increased symptoms which interfere with lifting, carrying and reaching."

Remark 5. Functional loss

BILATERAL: Loss of ROM limits the ability to function normally because it degrades the operation of skeletal joints in all domains of normally expected capability in an occupational environment.

Remark 6. BILATERAL Active & Passive ROM

BILATERAL:

ACTIVE ROM: joint movements were measured in the standing position with 10 pound dumbbells held in each hand. This loaded the joints to best simulate actual function in a physically demanding, non-sedentary occupational environment. This also measured ROM under "**WEIGHT-BEARING**" conditions which is most sensibly done during examination of active ROM.

PASSIVE ROM: joint movements were measured only against the resistance of gravity - that is, without any dumbbells held in the hands. This unloaded the joints to the maximum practical extent to best simulate function in a lighter-duty, sedentary occupational environment. This also measured ROM under "**NONWEIGHT-BEARING**" conditions which is most sensibly done during examination of passive ROM.

The proper examination of joint ROM is addressed further in an additional appendix.

Remark 7. Evidence of pain

BILATERAL: ROM was limited by pain. Loss of ROM limits the ability to function normally because it degrades the operation of skeletal joints in all domains of normally expected capability

in an occupational environment. Crepitus in the right elbow is due to the claimed condition. Left elbow has crepitus due to the left elbow condition which is not claimed. The elbows and associated soft tissues were moderately tender; on the right this is due to the claimed condition.

Remark 8. Estimated ROM after repeated use over time and during flare-ups

BILATERAL: The estimated ROM was based on all procurable evidence including my medical expertise as well as a thorough medical history incorporating lay statements from the Veteran.

Remark 9. Additional factors contributing to disability

BILATERAL: The selected factors from the above list contribute to disability by interfering with the normal mechanical functions of the body which then leads to difficulty with the basic activities of daily living.

Remark 10. Other impairments

Not applicable.

Remark 11. Surgical procedures

Not applicable.

Remark 12. Other findings, scars, and assistive devices

Not applicable.

Remark 13. Diagnostic testing

BILATERAL: Normal x-ray studies. Reports enclosed.

Remark 14. Functional impact

RIGHT: All occupational tasks (sedentary and non-sedentary) are impacted due to interference with lifting, carrying, and reaching, and due to distraction and lack of concentration from chronic pain.

LEFT: Not applicable as the left elbow condition is not claimed.

Remark 15. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might~~

**SHOULDER AND ARM CONDITIONS
DISABILITY BENEFITS QUESTIONNAIRE**

Name of Claimant/Veteran: <div style="background-color: black; width: 100px; height: 15px;"></div>	Claimant/Veteran's Social Security Number: <div style="background-color: black; width: 100px; height: 15px;"></div>	Date of Examination: <div style="background-color: black; width: 100px; height: 15px;"></div>
---	--	--

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:

Remark 1.

- 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? Remark 1.

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.

Remark 2.

DOMINANT HAND

Dominant hand: Right Left Ambidextrous

SECTION I - DIAGNOSIS

1A. List the claimed conditions that pertain to this questionnaire: Shoulder condition.

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, 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:
<input type="checkbox"/> Shoulder strain	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Shoulder impingement syndrome	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Bicipital tendonitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Bicipital tendon tear	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Rotator cuff tendonitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____

SECTION I - DIAGNOSIS (continued)

	Side affected:			ICD Code:	Date of diagnosis:		
<input checked="" type="checkbox"/> Rotator cuff tear	<input checked="" type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	S46.0	Right: 2008	Left: _____	_____
<input type="checkbox"/> Labral tear, including SLAP (superior labral anterior posterior lesion)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Subacromial/subdeltoid bursitis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Glenohumeral joint osteoarthritis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input checked="" type="checkbox"/> Acromioclavicular joint osteoarthritis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input checked="" type="checkbox"/> Both	M19.01	Right: 2008	Left: 2020	_____
<input type="checkbox"/> Ankylosis of glenohumeral articulations (shoulder joint)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Glenohumeral joint instability	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Glenohumeral joint dislocation/recurrent dislocation	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Shoulder joint replacement (total shoulder arthroplasty/hemiarthroplasty)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Acromioclavicular joint separation	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Degenerative arthritis, other than post-traumatic	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Arthritis, gonorrheal	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Arthritis, pneumococcic	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Arthritis, streptococcic	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Arthritis, syphilitic	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Arthritis, rheumatoid (multi joints)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Post traumatic arthritis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Arthritis, typhoid	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Other specified forms of arthropathy (excluding gout) (specify)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____

Remark 3.

<input type="checkbox"/> Osteoporosis, residuals of	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Osteomalacia, residuals of	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Bones, neoplasm, benign	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Osteitis deformans	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Gout	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Myositis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Heterotopic ossification	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Tendinopathy (select one if known)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Tendinitis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Tendinosis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Tenosynovitis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____
<input type="checkbox"/> Inflammatory other types (specify)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____	_____

Remark 3.

Other (specify)

Other diagnosis #1 Remark 3. _____

Side affected: Right Left Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

Other diagnosis #2 Remark 3. _____

Side affected: Right Left Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

If there are additional diagnoses that pertain to shoulder and/or arm conditions, list using above format:

Remark 3. _____

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's shoulder and/or arm condition (brief summary):

Remark 4. _____

SECTION II - MEDICAL HISTORY (continued)

2B. Does the Veteran report flare ups of the shoulder and/or arm? 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:

Remark 4.

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:

Remark 4.

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.

Right shoulder	Left shoulder
3A. Initial ROM measurements	3A. Initial ROM measurements
<input type="checkbox"/> All normal <input checked="" type="checkbox"/> Abnormal or outside of normal range <input type="checkbox"/> Unable to test <input type="checkbox"/> Not indicated	<input type="checkbox"/> All normal <input checked="" type="checkbox"/> Abnormal or outside of normal range <input type="checkbox"/> Unable to test <input type="checkbox"/> Not indicated
If "Unable to test" or "Not indicated" please explain:	If "Unable to test" or "Not indicated" please explain:
If ROM is outside of "normal" range, but is normal for the Veteran (for reason other than a shoulder/arm condition, such as age, body habitus, neurologic disease), please describe:	If ROM is outside of "normal" range, but is normal for the Veteran (for reason other than a shoulder/arm condition, such as age, body habitus, neurologic disease), please describe:
If abnormal, does the range of motion itself contribute to a functional loss? (if yes, please explain) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If abnormal, does the range of motion itself contribute to a functional loss? (if yes, please explain) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Remark 4.	Remark 4.
Note: For any joint condition, examiners should address pain on both passive and active motion, and on both weight bearing and nonweight bearing. Examiners should also test the contralateral joint (unless medically contraindicated). If testing cannot be performed or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation must be given below. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).	
Can testing be performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, provide an explanation:	Can testing be performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, provide an explanation:
If this is the unclaimed joint, is it: <input type="checkbox"/> Damaged <input type="checkbox"/> Undamaged	If this is the unclaimed joint, is it: <input type="checkbox"/> Damaged <input type="checkbox"/> Undamaged
If undamaged, range of motion testing must be conducted.	If undamaged, range of motion testing must be conducted.

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

3A. Initial ROM measurements (continued)

Active Range of Motion (ROM) Perform active range of motion and provide the ROM values.

Flexion endpoint (180 degrees): 90 degrees

Abduction endpoint (180 degrees): 90 degrees

Internal rotation endpoint (90 degrees): 90 degrees

External rotation endpoint (90 degrees): 45 degrees

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

Flexion Internal rotation

Abduction External rotation

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

90 Flexion degree endpoint (if different than above)

90 Abduction degree endpoint (if different than above)

90 Internal rotation degree endpoint (if different than above)

45 External rotation degree endpoint (if different than above)

Remark 5.

Passive Range of Motion Perform passive ROM and provide the ROM values.

Flexion endpoint (180 degrees): 120 degrees Same as active ROM

Abduction endpoint (180 degrees): 120 degrees Same as active ROM

Internal rotation endpoint (90 degrees): 90 degrees Same as active ROM

External rotation endpoint (90 degrees): 60 degrees Same as active ROM

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

Flexion Internal rotation

Abduction External rotation

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

120 Flexion degree endpoint (if different than above)

120 Abduction degree endpoint (if different than above)

90 Internal rotation degree endpoint (if different than above)

60 External rotation degree endpoint (if different than above)

Remark 5.

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)

3A. Initial ROM measurements (continued)

Active Range of Motion (ROM) Perform active range of motion and provide the ROM values.

Flexion endpoint (180 degrees): 90 degrees

Abduction endpoint (180 degrees): 90 degrees

Internal rotation endpoint (90 degrees): 90 degrees

External rotation endpoint (90 degrees): 45 degrees

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

Flexion Internal rotation

Abduction External rotation

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

90 Flexion degree endpoint (if different than above)

90 Abduction degree endpoint (if different than above)

90 Internal rotation degree endpoint (if different than above)

45 External rotation degree endpoint (if different than above)

Remark 5.

Passive Range of Motion Perform passive ROM and provide the ROM values.

Flexion endpoint (180 degrees): 120 degrees Same as active ROM

Abduction endpoint (180 degrees): 120 degrees Same as active ROM

Internal rotation endpoint (90 degrees): 90 degrees Same as active ROM

External rotation endpoint (90 degrees): 60 degrees Same as active ROM

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

Flexion Internal rotation

Abduction External rotation

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

120 Flexion degree endpoint (if different than above)

120 Abduction degree endpoint (if different than above)

90 Internal rotation degree endpoint (if different than above)

60 External rotation degree endpoint (if different than above)

Remark 5.

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)

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

<p>3A. Initial ROM measurements (continued)</p> <p>Right shoulder</p> <p>Comments:</p> <div style="border: 1px solid black; height: 40px; margin-top: 5px;">Remark 6.</div> <p>Is there objective evidence of crepitus? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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).</p> <div style="border: 1px solid black; height: 40px; margin-top: 5px;">Remark 6.</div>	<p>3A. Initial ROM measurements (continued)</p> <p>Left shoulder</p> <p>Comments:</p> <div style="border: 1px solid black; height: 40px; margin-top: 5px;">Remark 6.</div> <p>Is there objective evidence of crepitus? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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).</p> <div style="border: 1px solid black; height: 40px; margin-top: 5px;">Remark 6.</div>
<p>3B. Observed repetitive use ROM</p> <p>Is the Veteran able to perform repetitive use testing with at least three repetitions? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain:</p> <div style="border: 1px solid black; height: 40px; margin-top: 5px;">Remark 7.</div> <p>Is there additional loss of function or range of motion after three repetitions? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If yes, please respond to the following after the completion of the three repetitions:</p> <p>Flexion endpoint (180 degrees): <u> N/A </u> degrees</p> <p>Abduction endpoint (180 degrees): <u> N/A </u> degrees</p> <p>Internal rotation endpoint (90 degrees): <u> N/A </u> degrees</p> <p>External rotation endpoint (90 degrees): <u> N/A </u> degrees</p> <p>Select factors that cause this functional loss (check all that apply):</p> <p><input checked="" type="checkbox"/> N/A <input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination</p> <p><input type="checkbox"/> Other <u> Remark 7 </u></p>	<p>3B. Observed repetitive use ROM</p> <p>Is the Veteran able to perform repetitive use testing with at least three repetitions? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain:</p> <div style="border: 1px solid black; height: 40px; margin-top: 5px;">Remark 7.</div> <p>Is there additional loss of function or range of motion after three repetitions? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If yes, please respond to the following after the completion of the three repetitions:</p> <p>Flexion endpoint (180 degrees): <u> N/A </u> degrees</p> <p>Abduction endpoint (180 degrees): <u> N/A </u> degrees</p> <p>Internal rotation endpoint (90 degrees): <u> N/A </u> degrees</p> <p>External rotation endpoint (90 degrees): <u> N/A </u> degrees</p> <p>Select factors that cause this functional loss (check all that apply):</p> <p><input checked="" type="checkbox"/> N/A <input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination</p> <p><input type="checkbox"/> Other <u> Remark 7 </u></p>
<p>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. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare ups even if not directly observed during a flare up and/or after repeated use over time.</p>	
<p>3C. Repeated use over time</p> <p>Is the Veteran being examined immediately after repeated use over time? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select factors that cause this functional loss (check all that apply):</p> <p><input type="checkbox"/> N/A <input checked="" type="checkbox"/> Pain <input checked="" type="checkbox"/> Fatigability <input checked="" type="checkbox"/> Weakness</p> <p><input checked="" type="checkbox"/> Lack of endurance <input checked="" type="checkbox"/> Incoordination</p> <p><input type="checkbox"/> Other <u> Remark 8 </u></p>	<p>3C. Repeated use over time</p> <p>Is the Veteran being examined immediately after repeated use over time? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select factors that cause this functional loss (check all that apply):</p> <p><input type="checkbox"/> N/A <input checked="" type="checkbox"/> Pain <input checked="" type="checkbox"/> Fatigability <input checked="" type="checkbox"/> Weakness</p> <p><input checked="" type="checkbox"/> Lack of endurance <input checked="" type="checkbox"/> Incoordination</p> <p><input type="checkbox"/> Other <u> Remark 8 </u></p>

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

3C.Repeated use over time (continued)

Right shoulder

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.

Flexion endpoint (180 degrees): 90 degrees

Abduction endpoint (180 degrees): 90 degrees

Internal rotation endpoint (90 degrees): 90 degrees

External rotation endpoint (90 degrees): 45 degrees

The examiner should provide the estimated range of motion 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 here. (Must be specific to the case and based on all procurable evidence.)

Remark 8.

3C.Repeated use over time (continued)

Left shoulder

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.

Flexion endpoint (180 degrees): 90 degrees

Abduction endpoint (180 degrees): 90 degrees

Internal rotation endpoint (90 degrees): 90 degrees

External rotation endpoint (90 degrees): 45 degrees

The examiner should provide the estimated range of motion 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 here. (Must be specific to the case and based on all procurable evidence.)

Remark 8.

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 Weakness

Lack of endurance Incoordination

Other Remark 8.

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.

Flexion endpoint (180 degrees): 90 degrees

Abduction endpoint (180 degrees): 90 degrees

Internal rotation endpoint (90 degrees): 90 degrees

External rotation endpoint (90 degrees): 90 degrees

The examiner should provide the estimated range of motion 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 here. (Must be specific to the case and based on all procurable evidence.)

Remark 8.

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 Weakness

Lack of endurance Incoordination

Other Remark 8.

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.

Flexion endpoint (180 degrees): 90 degrees

Abduction endpoint (180 degrees): 90 degrees

Internal rotation endpoint (90 degrees): 90 degrees

External rotation endpoint (90 degrees): 90 degrees

The examiner should provide the estimated range of motion 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 here. (Must be specific to the case and based on all procurable evidence.)

Remark 8.

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

3E. Additional factors contributing to disability

In addition to those addressed above, are there additional contributing factors of disability? Select all that apply and describe:

- None
- Interference with sitting
- Interference with standing
- Swelling
- Disturbance of locomotion
- Deformity
- Less movement than normal
- More movement than normal
- Weakened movement
- Atrophy of disuse
- Instability of station
- Other, describe:

Please describe additional contributing factors of disability here:

Remark 8.

3E. Additional factors contributing to disability

In addition to those addressed above, are there additional contributing factors of disability? Select all that apply and describe:

- None
- Interference with sitting
- Interference with standing
- Swelling
- Disturbance of locomotion
- Deformity
- Less movement than normal
- More movement than normal
- Weakened movement
- Atrophy of disuse
- Instability of station
- Other, describe:

Please describe additional contributing factors of disability here:

Remark 8.

SECTION IV - MUSCLE ATROPHY

Right shoulder

- 4A. Does the Veteran have muscle atrophy? Yes No
- 4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section?
 Yes No If no, provide rationale:

Remark 9.

4C. For any muscle atrophy due to a diagnosis listed in Section I, 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 such as "10cm above the anterior elbow crease" here):

Remark 9.

Circumference of more normal side: _____ cm Circumference of atrophied side: _____ cm

Left shoulder

- 4A. Does the Veteran have muscle atrophy? Yes No
- 4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section?
 Yes No If no, provide rationale:

Remark 9.

4C. For any muscle atrophy due to a diagnosis listed in Section I, 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 such as "10cm above the anterior elbow crease" here):

Remark 9.

Circumference of more normal side: _____ cm Circumference of atrophied side: _____ cm

SECTION V - ANKYLOSIS

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

- 5A. Is there ankylosis of the scapulohumeral (glenohumeral) articulation (shoulder joint) (i.e., the scapula and humerus move as one piece)? Yes No
 If yes, indicate the severity of the ankylosis:

- Ankylosis in abduction up to 60 degrees; can reach mouth and head (favorable ankylosis)
- Ankylosis in abduction between favorable and unfavorable (intermediate ankylosis)
- Ankylosis in abduction at 25 degrees or less from side (unfavorable ankylosis)

5B. Indicate angle of ankylosis in degrees of abduction: _____ degrees

5C. If ankylosed, is there involvement of Muscle Group I (trapezius, levator scapulae, serratus magnus) and II (pectoralis major II (costosternal), latissimus dorsi and teres major, pectoralis minor, rhomboid)? Yes No If yes, complete the Muscle Injuries questionnaire.

- 5A. Is there ankylosis of the scapulohumeral (glenohumeral) articulation (shoulder joint) (i.e., the scapula and humerus move as one piece)? Yes No
 If yes, indicate the severity of the ankylosis:

- Ankylosis in abduction up to 60 degrees; can reach mouth and head (favorable ankylosis)
- Ankylosis in abduction between favorable and unfavorable (intermediate ankylosis)
- Ankylosis in abduction at 25 degrees or less from side (unfavorable ankylosis)

5B. Indicate angle of ankylosis in degrees of abduction: _____ degrees

5C. If ankylosed, is there involvement of Muscle Group I (trapezius, levator scapulae, serratus magnus) and II (pectoralis major II (costosternal), latissimus dorsi and teres major, pectoralis minor, rhomboid)? Yes No If yes, complete the Muscle Injuries questionnaire.

SECTION VI - ROTATOR CUFF CONDITIONS

<p>6A. Complete the following:</p> <p>Hawkins' Impingement Test: Forward flex the arm to 90 degrees with the elbow bent to 90 degrees. Internally rotate arm. Pain on internal rotation indicates a positive test; may signify rotator cuff tendinopathy or tear.</p> <p><input checked="" type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unable to test <input type="checkbox"/> N/A</p> <p>Empty Can Test: Abduct arm to 90 degrees and forward flex 30 degrees. Patient turns thumbs down and resists downward force applied by the examiner. Weakness indicates a positive test; may indicate rotator cuff pathology, including supraspinatus tendinopathy or tear.</p> <p><input checked="" type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unable to test <input type="checkbox"/> N/A</p> <p>External rotation/infraspinatus strength test: Patient holds arms at side with elbow flexed 90 degrees. Patient externally rotates against resistance. Weakness indicates a positive test; may be associated with infraspinatus tendinopathy or tear.</p> <p><input checked="" type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unable to test <input type="checkbox"/> N/A</p> <p>Lift off subscapularis test: Patient internally rotates arm behind lower back, pushes against examiner's hand. Weakness indicates a positive test; may indicate subscapularis tendinopathy or tear.</p> <p><input checked="" type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unable to test <input type="checkbox"/> N/A</p> <p>6B. If unable to test, is a rotator cuff condition suspected? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:</p>	<p>6A. Complete the following:</p> <p>Hawkins' Impingement Test: Forward flex the arm to 90 degrees with the elbow bent to 90 degrees. Internally rotate arm. Pain on internal rotation indicates a positive test; may signify rotator cuff tendinopathy or tear.</p> <p><input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Unable to test <input type="checkbox"/> N/A</p> <p>Empty Can Test: Abduct arm to 90 degrees and forward flex 30 degrees. Patient turns thumbs down and resists downward force applied by the examiner. Weakness indicates a positive test; may indicate rotator cuff pathology, including supraspinatus tendinopathy or tear.</p> <p><input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Unable to test <input type="checkbox"/> N/A</p> <p>External rotation/infraspinatus strength test: Patient holds arms at side with elbow flexed 90 degrees. Patient externally rotates against resistance. Weakness indicates a positive test; may be associated with infraspinatus tendinopathy or tear.</p> <p><input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Unable to test <input type="checkbox"/> N/A</p> <p>Lift off subscapularis test: Patient internally rotates arm behind lower back, pushes against examiner's hand. Weakness indicates a positive test; may indicate subscapularis tendinopathy or tear.</p> <p><input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Unable to test <input type="checkbox"/> N/A</p> <p>6B. If unable to test, is a rotator cuff condition suspected? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:</p>
<p>Remark 10.</p>	<p>Remark 10.</p>

SECTION VII - SHOULDER INSTABILITY, DISLOCATION OR LABRAL PATHOLOGY

<p>Right shoulder</p> <p>7A. Complete the following:</p> <p>Crank Apprehension and Relocation Test: With patient supine, abduct patient's arm to 90 degrees and flex elbow 90 degrees. Pain and sense of instability with further external rotation may indicate shoulder instability.</p> <p><input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Unable to test <input type="checkbox"/> N/A</p> <p>7B. If unable to test, is shoulder instability, dislocation or labral pathology suspected? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:</p>	<p>Left shoulder</p> <p>7A. Complete the following:</p> <p>Crank Apprehension and Relocation Test: With patient supine, abduct patient's arm to 90 degrees and flex elbow 90 degrees. Pain and sense of instability with further external rotation may indicate shoulder instability.</p> <p><input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Unable to test <input type="checkbox"/> N/A</p> <p>7B. If unable to test, is shoulder instability, dislocation or labral pathology suspected? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:</p>
<p>Remark 10.</p>	<p>Remark 10.</p>
<p>7C. Is there shoulder instability, dislocation or labral pathology? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>7C. Is there shoulder instability, dislocation or labral pathology? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
<p>7D. Does the Veteran have mechanical symptoms (clicking, catching, etc.)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>7D. Does the Veteran have mechanical symptoms (clicking, catching, etc.)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
<p>7E. Are there current residuals of recurrent dislocation (subluxation) of the glenohumeral (scapulohumeral) joint? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, check all that apply:</p> <p><input type="checkbox"/> Infrequent episodes and guarding of movement only at shoulder level (flexion and/or abduction at 90°)</p> <p><input type="checkbox"/> Frequent episodes and guarding of all arm movements</p> <p>Affects range of motion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>7E. Are there current residuals of recurrent dislocation (subluxation) of the glenohumeral (scapulohumeral) joint? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, check all that apply:</p> <p><input type="checkbox"/> Infrequent episodes and guarding of movement only at shoulder level (flexion and/or abduction at 90°)</p> <p><input type="checkbox"/> Frequent episodes and guarding of all arm movements</p> <p>Affects range of motion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

SECTION VIII - CLAVICLE, SCAPULA, ACROMIOCLAVICULAR (AC) JOINT AND STERNOCLAVICULAR JOINT CONDITIONS

8A. Complete the following:

Cross body adduction test: Passively adduct arm across the patient's body toward the contralateral shoulder. Pain may indicate acromioclavicular joint pathology.

- Positive Negative Unable to test N/A

8B. If unable to test, is a clavicle, scapula, acromioclavicular (AC) joint or sternoclavicular joint condition suspected? Yes No If yes, please describe:

Remark 10.

8C. Is there a clavicle, scapula, acromioclavicular (AC) joint, sternoclavicular joint condition or other impairment? Yes No If yes, indicate severity:

- Malunion of clavicle or scapula
 Nonunion of clavicle or scapula without loose movement
 Nonunion of clavicle or scapula with loose movement
 Dislocation (acromioclavicular separation or sternoclavicular dislocation)
 Other (describe):

Remark 10.

8D. Does the clavicle or scapula condition affect range of motion of the shoulder (glenohumeral joint)? Yes No

8E. Is there tenderness on palpation of the AC joint? Yes No

8A. Complete the following:

Cross body adduction test: Passively adduct arm across the patient's body toward the contralateral shoulder. Pain may indicate acromioclavicular joint pathology.

- Positive Negative Unable to test N/A

8B. If unable to test, is a clavicle, scapula, acromioclavicular (AC) joint or sternoclavicular joint condition suspected? Yes No If yes, please describe:

Remark 10.

8C. Is there a clavicle, scapula, acromioclavicular (AC) joint, sternoclavicular joint condition or other impairment? Yes No If yes, indicate severity:

- Malunion of clavicle or scapula
 Nonunion of clavicle or scapula without loose movement
 Nonunion of clavicle or scapula with loose movement
 Dislocation (acromioclavicular separation or sternoclavicular dislocation)
 Other (describe):

Remark 10.

8D. Does the clavicle or scapula condition affect range of motion of the shoulder (glenohumeral joint)? Yes No

8E. Is there tenderness on palpation of the AC joint? Yes No

SECTION IX - CONDITIONS OR IMPAIRMENTS OF THE HUMERUS

9A. Does the Veteran have loss of head (flail shoulder), nonunion (false flail shoulder), or fibrous union of the humerus? Yes No If yes, check all that apply:

- Loss of head (flail shoulder) Nonunion (false flail shoulder) Fibrous union

9B. Does the Veteran have malunion of the humerus with moderate or marked deformity? Yes No If yes, indicate severity:

- Moderate deformity Marked deformity

9C. Does the humerus condition affect range of motion of the shoulder (glenohumeral joint)? Yes No

9A. Does the Veteran have loss of head (flail shoulder), nonunion (false flail shoulder), or fibrous union of the humerus? Yes No If yes, check all that apply:

- Loss of head (flail shoulder) Nonunion (false flail shoulder) Fibrous union

9B. Does the Veteran have malunion of the humerus with moderate or marked deformity? Yes No If yes, indicate severity:

- Moderate deformity Marked deformity

9C. Does the humerus condition affect range of motion of the shoulder (glenohumeral joint)? Yes No

SECTION X - SURGICAL PROCEDURES

10. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):

- No surgery
 Total shoulder joint replacement Date of surgery: Remark 11.

Residuals: None Intermediate degrees of residual weakness, pain, or limitation of motion
 Chronic residuals consisting of severe painful motion or weakness
 Other residuals, describe: Remark 11.

Arthroscopic or other shoulder surgery
 Date of Surgery: Remark 11. Type of Surgery: Remark 11.

Describe residuals:
 Remark 11.

10. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):

- No surgery
 Total shoulder joint replacement Date of surgery: Remark 11.

Residuals: None Intermediate degrees of residual weakness, pain, or limitation of motion
 Chronic residuals consisting of severe painful motion or weakness
 Other residuals, describe: Remark 11.

Arthroscopic or other shoulder surgery
 Date of Surgery: Remark 11. Type of Surgery: Remark 11.

Describe residuals:
 Remark 11.

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

11A. Does the Veteran have any other pertinent physical findings, complications, signs, or symptoms related to any conditions listed in the diagnosis section above?
 Yes No If yes, describe (brief summary):

Remark 12.

11B. 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?
 Yes No If yes, also complete the appropriate dermatological questionnaire.

11C. Comments, if any:

Remark 12.

SECTION XII - ASSISTIVE DEVICES

12A. 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: Remark 12. Frequency of use: Occasional Regular Constant

12B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition:

Remark 12.

SECTION XIII - 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.

13A. Due to the Veteran's shoulder or arm 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

13B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function, and provide specific examples (brief summary):

Remark 12.

SECTION XIV - 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.

14A. Have imaging studies been performed in conjunction with this examination? Yes No

14B. If yes, is degenerative or post traumatic arthritis documented? Yes No If yes, indicate side: Right Left Both

14C. If yes, provide type of test or procedure, date and results (brief summary):

Remark 13.

Remark 3. Diagnosis

~~The dates of diagnosis on this DBQ may differ from those found elsewhere, especially in C&P exams. The VA provides clear and unambiguous direction on this matter in a note on all of its DBQs: "Date of diagnosis can be. . . **AN APPROXIMATE DATE DETERMINED THROUGH RECORD REVIEW OR REPORTED HISTORY.**" It is common practice for C&P examiners to disregard this guidance along with the reported history from the Veteran. Instead, they often record the date when a medical record first contains a diagnosis despite no requirement whatsoever from the VA to have such a correspondence on the DBQs. In contrast, I have completed a careful record review and medical history to determine the approximate date of some observable sign or symptom that was the first manifestation of a disability. This date most accurately reflects the beginning of impairment. It often long precedes the date in a medical record, sometimes by many years. There are no additional diagnoses.~~

Remark 4. Medical history and functional loss

See associated medical opinion for medical history.

Flare-ups: "Flare-ups interfere with all of my work and activities of daily living."

Repeated use over time: "Repeated use over time results in increased symptoms which interfere with lifting, carrying and reaching."

Functional loss: BILATERAL - Loss of ROM limits the ability to function normally because it degrades the operation of skeletal joints in all domains of normally expected capability in an occupational environment.

Remark 5. BILATERAL Active & Passive ROM

BILATERAL:

ACTIVE ROM: joint movements were measured in the standing position with 10 pound dumbbells held in each hand. This loaded the joints to best simulate actual function in a physically demanding, non-sedentary occupational environment. This also measured ROM under "**WEIGHT-BEARING**" conditions which is most sensibly done during examination of active ROM.

PASSIVE ROM: joint movements were measured only against the resistance of gravity - that is, without any dumbbells held in the hands. This unloaded the joints to the maximum practical extent to best simulate function in a lighter-duty, sedentary occupational environment. This also measured ROM under "**NONWEIGHT-BEARING**" conditions which is most sensibly done during examination of passive ROM.

The proper examination of joint ROM is addressed further in an additional appendix.

Remark 6. Evidence of pain

BILATERAL: Shoulder ROM was limited by pain. Loss of ROM limits the ability to function normally because it degrades the operation of skeletal joints in all domains of normally expected capability in an occupational environment. Crepitus in the shoulders is due to the claimed condition. The shoulders and associated soft tissues were moderately tender due to the claimed condition.

Remark 7. Observed repetitive use ROM

Not applicable.

Remark 8. Estimated ROM after repeated use over time and during flare-ups

BILATERAL: The estimated ROM was based on all procurable evidence including my medical expertise as well as a thorough medical history incorporating lay statements from the Veteran.

Additional factors: BILATERAL - The selected factors from the above list contribute to disability by interfering with the normal mechanical functions of the body which then leads to difficulty with the basic activities of daily living.

Remark 9. Muscle atrophy

Not applicable.

Remark 10. Assessment of rotator cuff, instability, and acromioclavicular (AC) joint

RIGHT: There is a known tear in the right rotator cuff. AC joint was tender to palpation and has known osteoarthritis. No instability.

LEFT: No rotator cuff condition. AC joint was tender to palpation and has known osteoarthritis. No instability.

Remark 11. Surgical procedures

Not applicable.

Remark 12. Other findings, scars, assistive devices, and remaining effective function

Not applicable.

Remark 13. Diagnostic testing

BILATERAL: Degenerative arthritis identified on x-ray studies. Reports enclosed. The abnormal imaging results are due to the claimed condition.

Remark 14. Functional impact

BILATERAL: All occupational tasks (sedentary and non-sedentary) are impacted due to interference with lifting, carrying, and reaching, and due to distraction and lack of concentration from chronic pain.

Remark 15. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is~~

**HIP AND THIGH CONDITIONS
DISABILITY BENEFITS QUESTIONNAIRE**

Name of Claimant/Veteran: <div style="background-color: black; width: 100%; height: 20px;"></div>	Claimant/Veteran's Social Security Number: <div style="background-color: black; width: 100%; height: 20px;"></div>	Date of Examination: <div style="background-color: black; width: 100%; height: 20px;"></div>
--	---	---

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

Remark 1:

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?

Remark 1:

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.

Remark 2:

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 conditions that pertain to this questionnaire: Hip condition.

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, 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:
<input checked="" type="checkbox"/> Osteoarthritis, hip	<input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Both	M16.0	Right: 1999 Left: 1999
<input type="checkbox"/> Hip joint replacement	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Hip joint resurfacing	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Trochanteric pain syndrome (includes trochanteric bursitis)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Femoral acetabular impingement syndrome (includes labral tears)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both		Right: _____ Left: _____

SECTION I - DIAGNOSIS (continued)

	Side affected:			ICD Code:	Date of diagnosis:	
	Right	Left	Both		Right:	Left:
<input type="checkbox"/> Iliopsoas tendinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Femoral neck stress fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Avascular necrosis, hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Ankylosis of hip joint	<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, pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Arthritis, streptococcal	<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 joints)	<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"/>	_____	_____	_____
<hr/>						
<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"/>	_____	_____	_____
<hr/>						
<input type="checkbox"/> Other (specify)	_____					
Other diagnosis #1	_____					
Side affected:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	ICD Code: _____	Date of diagnosis: Right: _____	Left: _____
Other diagnosis #2	_____					
Side affected:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	ICD Code: _____	Date of diagnosis: Right: _____	Left: _____
Other diagnosis #3	_____					
Side affected:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	ICD Code: _____	Date of diagnosis: Right: _____	Left: _____
If there are additional diagnoses that pertain to hip and thigh conditions, list using above format:						
Remark 3.						

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's hip or thigh condition (brief summary):

Remark 4.

2B. Does the Veteran report flare ups of the hip or thigh? Yes No If yes, document the Veteran's description of the flare ups he/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.

Remark 4.

SECTION II - MEDICAL HISTORY (continued)

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.

Remark 4.

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.

RIGHT HIP	LEFT HIP
3A. Initial ROM measurements	3A. Initial ROM measurements
<input type="checkbox"/> All Normal <input checked="" type="checkbox"/> Abnormal or outside of normal range <input type="checkbox"/> Unable to test <input type="checkbox"/> Not indicated	<input type="checkbox"/> All Normal <input checked="" type="checkbox"/> Abnormal or outside of normal range <input type="checkbox"/> Unable to test <input type="checkbox"/> Not indicated
If "Unable to test" or "Not indicated" please explain:	If "Unable to test" or "Not indicated" please explain:
N/A	N/A
If ROM is outside of "normal" range, but is normal for the Veteran (for reason other than a hip/high condition, such as age, body habitus, neurologic disease), please describe:	If ROM is outside of "normal" range, but is normal for the Veteran (for reason other than a hip/high condition, such as age, body habitus, neurologic disease), please describe:
N/A	N/A
If abnormal, does the range of motion itself contribute to a functional loss? (if yes, please explain) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If abnormal, does the range of motion itself contribute to a functional loss? (if yes, please explain) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Remark 5.	Remark 5.

Note: For any joint condition, examiners should address pain on both passive and active motion, and on both weight bearing and nonweight bearing. Examiners should also test the contralateral joint (unless medically contraindicated). If testing cannot be performed or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation must be given below. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).

Can testing be performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, provide an explanation:	Can testing be performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, provide an explanation:
N/A	N/A
If this is the unclaimed joint, is it: <input type="checkbox"/> Damaged <input type="checkbox"/> Undamaged	If this is the unclaimed joint, is it: <input type="checkbox"/> Damaged <input type="checkbox"/> Undamaged
If undamaged, range of motion testing must be conducted.	If undamaged, range of motion testing must be conducted.
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.
Flexion endpoint (125 degrees) <u>20</u> degrees	Flexion endpoint (125 degrees) <u>20</u> degrees
Extension endpoint (30 degrees) <u>5</u> degrees	Extension endpoint (30 degrees) <u>5</u> degrees
Abduction endpoint (45 degrees) <u>10</u> degrees	Abduction endpoint (45 degrees) <u>10</u> degrees
Adduction endpoint (25 degrees) <u>10</u> degrees	Adduction endpoint (25 degrees) <u>10</u> degrees
External rotation endpoint (60 degrees) <u>30</u> degrees	External rotation endpoint (60 degrees) <u>30</u> degrees
Internal rotation endpoint (40 degrees) <u>20</u> degrees	Internal rotation endpoint (40 degrees) <u>20</u> degrees

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

RIGHT HIP

3A. Initial ROM measurements (continued)

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

Flexion Abduction External Rotation
 Extension Adduction Internal Rotation

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

20	Flexion degree endpoint (if different than above)	10	Adduction degree endpoint (if different than above)
5	Extension degree endpoint (if different than above)	30	External Rotation degree endpoint (if different than above)
10	Abduction degree endpoint (if different than above)	20	Internal Rotation degree endpoint (if different than above)

Remark 6.

Does a limitation in adduction prevent the Veteran from crossing his/her legs?
 Yes No

Passive Range of Motion Perform passive range of motion and provide the ROM values.

Flexion endpoint (125 degrees)	70	degrees	<input type="checkbox"/> Same as active ROM
Extension endpoint (30 degrees)	15	degrees	<input type="checkbox"/> Same as active ROM
Abduction endpoint (45 degrees)	20	degrees	<input type="checkbox"/> Same as active ROM
Adduction endpoint (25 degrees)	15	degrees	<input type="checkbox"/> Same as active ROM
External rotation endpoint (60 degrees)	45	degrees	<input type="checkbox"/> Same as active ROM
Internal rotation endpoint (40 degrees)	25	degrees	<input type="checkbox"/> Same as active ROM

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

Flexion Abduction External Rotation
 Extension Adduction Internal Rotation

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

70	Flexion degree endpoint (if different than above)	15	Adduction degree endpoint (if different than above)
15	Extension degree endpoint (if different than above)	45	External Rotation degree endpoint (if different than above)
20	Abduction degree endpoint (if different than above)	25	Internal Rotation degree endpoint (if different than above)

Remark 6.

Does a limitation in passive adduction prevent the Veteran from crossing his/her legs?
 Yes No

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

causes functional loss (if checked describe in the comments box below) does not result in/cause functional loss.

Comments:

Remark 7.

LEFT HIP

3A. Initial ROM measurements (continued)

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

Flexion Abduction External Rotation
 Extension Adduction Internal Rotation

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

20	Flexion degree endpoint (if different than above)	10	Adduction degree endpoint (if different than above)
5	Extension degree endpoint (if different than above)	30	External Rotation degree endpoint (if different than above)
10	Abduction degree endpoint (if different than above)	20	Internal Rotation degree endpoint (if different than above)

Remark 6.

Does a limitation in adduction prevent the Veteran from crossing his/her legs?
 Yes No

Passive Range of Motion Perform passive range of motion and provide the ROM values.

Flexion endpoint (125 degrees)	70	degrees	<input type="checkbox"/> Same as active ROM
Extension endpoint (30 degrees)	15	degrees	<input type="checkbox"/> Same as active ROM
Abduction endpoint (45 degrees)	20	degrees	<input type="checkbox"/> Same as active ROM
Adduction endpoint (25 degrees)	15	degrees	<input type="checkbox"/> Same as active ROM
External rotation endpoint (60 degrees)	45	degrees	<input type="checkbox"/> Same as active ROM
Internal rotation endpoint (40 degrees)	25	degrees	<input type="checkbox"/> Same as active ROM

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

Flexion Abduction External Rotation
 Extension Adduction Internal Rotation

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

70	Flexion degree endpoint (if different than above)	15	Adduction degree endpoint (if different than above)
15	Extension degree endpoint (if different than above)	45	External Rotation degree endpoint (if different than above)
20	Abduction degree endpoint (if different than above)	25	Internal Rotation degree endpoint (if different than above)

Remark 6.

Does a limitation in passive adduction prevent the Veteran from crossing his/her legs?
 Yes No

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

causes functional loss (if checked describe in the comments box below) does not result in/cause functional loss.

Comments:

Remark 7.

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

RIGHT HIP	LEFT HIP
3A. Initial ROM measurements (continued)	3A. Initial ROM measurements (continued)
Is there objective evidence of crepitus? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Is there objective evidence of crepitus? <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).	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).
Remark 7.	Remark 7.
3B. Observed repetitive use ROM	3B. Observed repetitive use ROM
Is the Veteran able to perform repetitive use testing with at least three repetitions? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:	Is the Veteran able to perform repetitive use testing with at least three repetitions? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:
Is there additional loss of function or range of motion after three repetitions? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Is there additional loss of function or range of motion after three repetitions? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If yes, please respond to the following after the completion of the three repetitions:	If yes, please respond to the following after the completion of the three repetitions:
Flexion endpoint (125 degrees) _____ degrees	Flexion endpoint (125 degrees) _____ degrees
Extension endpoint (30 degrees) _____ degrees	Extension endpoint (30 degrees) _____ degrees
Abduction endpoint (45 degrees) _____ degrees	Abduction endpoint (45 degrees) _____ degrees
Adduction endpoint (25 degrees) _____ degrees	Adduction endpoint (25 degrees) _____ degrees
External rotation endpoint (60 degrees) _____ degrees	External rotation endpoint (60 degrees) _____ degrees
Internal rotation endpoint (40 degrees) _____ degrees	Internal rotation endpoint (40 degrees) _____ degrees
Does limitation in adduction after observed repetitive use prevent the Veteran from crossing his/her legs? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Does limitation in adduction after observed repetitive use prevent the Veteran from crossing his/her legs? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Select factors that cause this functional loss: (check all that apply)	Select factors that cause this functional loss: (check all that apply)
<input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance	<input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance
<input type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input checked="" type="checkbox"/> N/A	<input type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input checked="" type="checkbox"/> N/A
<p>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. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare ups even if not directly observed during a flare up and/or after repeated use over time.</p>	
3C. Repeated use over time	3C. Repeated use over time
Is the Veteran being examined immediately after repeated use over time? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Is the Veteran being examined immediately after repeated use over time? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Select factors that cause this functional loss. (Check all that apply)	Select factors that cause this functional loss. (Check all that apply)
<input checked="" type="checkbox"/> Pain <input checked="" type="checkbox"/> Fatigability <input checked="" type="checkbox"/> Weakness <input checked="" type="checkbox"/> Lack of endurance	<input checked="" type="checkbox"/> Pain <input checked="" type="checkbox"/> Fatigability <input checked="" type="checkbox"/> Weakness <input checked="" type="checkbox"/> Lack of endurance
<input checked="" type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A	<input checked="" type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A

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

RIGHT HIP	LEFT HIP																																				
<p>3C. Repeated use over time (continued)</p> <p>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.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;">Flexion endpoint (125 degrees)</td> <td style="width:10%; text-align: center;">20</td> <td style="width:20%;">degrees</td> </tr> <tr> <td>Extension endpoint (30 degrees)</td> <td style="text-align: center;">5</td> <td>degrees</td> </tr> <tr> <td>Abduction endpoint (45 degrees)</td> <td style="text-align: center;">10</td> <td>degrees</td> </tr> <tr> <td>Adduction endpoint (25 degrees)</td> <td style="text-align: center;">10</td> <td>degrees</td> </tr> <tr> <td>External rotation endpoint (60 degrees)</td> <td style="text-align: center;">30</td> <td>degrees</td> </tr> <tr> <td>Internal rotation endpoint (40 degrees)</td> <td style="text-align: center;">20</td> <td>degrees</td> </tr> </table> <p>The examiner should provide the estimated range of motion 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.</p> <p>Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)</p>	Flexion endpoint (125 degrees)	20	degrees	Extension endpoint (30 degrees)	5	degrees	Abduction endpoint (45 degrees)	10	degrees	Adduction endpoint (25 degrees)	10	degrees	External rotation endpoint (60 degrees)	30	degrees	Internal rotation endpoint (40 degrees)	20	degrees	<p>3C. Repeated use over time (continued)</p> <p>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.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;">Flexion endpoint (125 degrees)</td> <td style="width:10%; text-align: center;">20</td> <td style="width:20%;">degrees</td> </tr> <tr> <td>Extension endpoint (30 degrees)</td> <td style="text-align: center;">5</td> <td>degrees</td> </tr> <tr> <td>Abduction endpoint (45 degrees)</td> <td style="text-align: center;">10</td> <td>degrees</td> </tr> <tr> <td>Adduction endpoint (25 degrees)</td> <td style="text-align: center;">10</td> <td>degrees</td> </tr> <tr> <td>External rotation endpoint (60 degrees)</td> <td style="text-align: center;">30</td> <td>degrees</td> </tr> <tr> <td>Internal rotation endpoint (40 degrees)</td> <td style="text-align: center;">20</td> <td>degrees</td> </tr> </table> <p>The examiner should provide the estimated range of motion 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.</p> <p>Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)</p>	Flexion endpoint (125 degrees)	20	degrees	Extension endpoint (30 degrees)	5	degrees	Abduction endpoint (45 degrees)	10	degrees	Adduction endpoint (25 degrees)	10	degrees	External rotation endpoint (60 degrees)	30	degrees	Internal rotation endpoint (40 degrees)	20	degrees
Flexion endpoint (125 degrees)	20	degrees																																			
Extension endpoint (30 degrees)	5	degrees																																			
Abduction endpoint (45 degrees)	10	degrees																																			
Adduction endpoint (25 degrees)	10	degrees																																			
External rotation endpoint (60 degrees)	30	degrees																																			
Internal rotation endpoint (40 degrees)	20	degrees																																			
Flexion endpoint (125 degrees)	20	degrees																																			
Extension endpoint (30 degrees)	5	degrees																																			
Abduction endpoint (45 degrees)	10	degrees																																			
Adduction endpoint (25 degrees)	10	degrees																																			
External rotation endpoint (60 degrees)	30	degrees																																			
Internal rotation endpoint (40 degrees)	20	degrees																																			
<p>Remark 8.</p>	<p>Remark 8.</p>																																				
<p>Does limitation in adduction after repeated use over time prevent the Veteran from crossing his/her legs? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>Does limitation in adduction after repeated use over time prevent the Veteran from crossing his/her legs? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>																																				
<p>3D. Flare ups</p> <p>Is the examination being conducted during a flare up? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare ups? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select factors that cause this functional loss. (Check all that apply)</p> <p><input checked="" type="checkbox"/> Pain <input checked="" type="checkbox"/> Fatigability <input checked="" type="checkbox"/> Weakness <input checked="" type="checkbox"/> Lack of endurance</p> <p><input checked="" type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A</p> <p>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.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;">Flexion endpoint (125 degrees)</td> <td style="width:10%; text-align: center;">20</td> <td style="width:20%;">degrees</td> </tr> <tr> <td>Extension endpoint (30 degrees)</td> <td style="text-align: center;">5</td> <td>degrees</td> </tr> <tr> <td>Abduction endpoint (45 degrees)</td> <td style="text-align: center;">10</td> <td>degrees</td> </tr> <tr> <td>Adduction endpoint (25 degrees)</td> <td style="text-align: center;">10</td> <td>degrees</td> </tr> <tr> <td>External rotation endpoint (60 degrees)</td> <td style="text-align: center;">30</td> <td>degrees</td> </tr> <tr> <td>Internal rotation endpoint (40 degrees)</td> <td style="text-align: center;">20</td> <td>degrees</td> </tr> </table>	Flexion endpoint (125 degrees)	20	degrees	Extension endpoint (30 degrees)	5	degrees	Abduction endpoint (45 degrees)	10	degrees	Adduction endpoint (25 degrees)	10	degrees	External rotation endpoint (60 degrees)	30	degrees	Internal rotation endpoint (40 degrees)	20	degrees	<p>3D. Flare ups</p> <p>Is the examination being conducted during a flare up? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare ups? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select factors that cause this functional loss. (Check all that apply)</p> <p><input checked="" type="checkbox"/> Pain <input checked="" type="checkbox"/> Fatigability <input checked="" type="checkbox"/> Weakness <input checked="" type="checkbox"/> Lack of endurance</p> <p><input checked="" type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A</p> <p>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.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;">Flexion endpoint (125 degrees)</td> <td style="width:10%; text-align: center;">20</td> <td style="width:20%;">degrees</td> </tr> <tr> <td>Extension endpoint (30 degrees)</td> <td style="text-align: center;">5</td> <td>degrees</td> </tr> <tr> <td>Abduction endpoint (45 degrees)</td> <td style="text-align: center;">10</td> <td>degrees</td> </tr> <tr> <td>Adduction endpoint (25 degrees)</td> <td style="text-align: center;">10</td> <td>degrees</td> </tr> <tr> <td>External rotation endpoint (60 degrees)</td> <td style="text-align: center;">30</td> <td>degrees</td> </tr> <tr> <td>Internal rotation endpoint (40 degrees)</td> <td style="text-align: center;">20</td> <td>degrees</td> </tr> </table>	Flexion endpoint (125 degrees)	20	degrees	Extension endpoint (30 degrees)	5	degrees	Abduction endpoint (45 degrees)	10	degrees	Adduction endpoint (25 degrees)	10	degrees	External rotation endpoint (60 degrees)	30	degrees	Internal rotation endpoint (40 degrees)	20	degrees
Flexion endpoint (125 degrees)	20	degrees																																			
Extension endpoint (30 degrees)	5	degrees																																			
Abduction endpoint (45 degrees)	10	degrees																																			
Adduction endpoint (25 degrees)	10	degrees																																			
External rotation endpoint (60 degrees)	30	degrees																																			
Internal rotation endpoint (40 degrees)	20	degrees																																			
Flexion endpoint (125 degrees)	20	degrees																																			
Extension endpoint (30 degrees)	5	degrees																																			
Abduction endpoint (45 degrees)	10	degrees																																			
Adduction endpoint (25 degrees)	10	degrees																																			
External rotation endpoint (60 degrees)	30	degrees																																			
Internal rotation endpoint (40 degrees)	20	degrees																																			

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

RIGHT HIP	LEFT HIP
3D. Flare ups (continued)	3D. Flare ups (continued)
<p>The examiner should provide the estimated range of motion 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.</p> <p>Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)</p>	<p>The examiner should provide the estimated range of motion 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.</p> <p>Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)</p>
Remark 8.	Remark 8.
Does limitation in adduction during flare ups prevent the Veteran from crossing his/her legs? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Does limitation in adduction during flare ups prevent the Veteran from crossing his/her legs? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3E. Additional factors contributing to disability	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:	In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:
<input type="checkbox"/> None <input checked="" type="checkbox"/> Interference with sitting <input checked="" type="checkbox"/> Interference with standing <input type="checkbox"/> Swelling <input checked="" type="checkbox"/> Disturbance of locomotion <input type="checkbox"/> Deformity <input checked="" type="checkbox"/> Less movement than normal <input type="checkbox"/> More movement than normal <input checked="" type="checkbox"/> Weakened movement <input type="checkbox"/> Atrophy of disuse <input type="checkbox"/> Instability of station <input type="checkbox"/> Other, describe:	<input type="checkbox"/> None <input checked="" type="checkbox"/> Interference with sitting <input checked="" type="checkbox"/> Interference with standing <input type="checkbox"/> Swelling <input checked="" type="checkbox"/> Disturbance of locomotion <input type="checkbox"/> Deformity <input checked="" type="checkbox"/> Less movement than normal <input type="checkbox"/> More movement than normal <input checked="" type="checkbox"/> Weakened movement <input type="checkbox"/> Atrophy of disuse <input type="checkbox"/> Instability of station <input type="checkbox"/> Other, describe:
Please describe additional contributing factors of disability:	Please describe additional contributing factors of disability:
Remark 9.	Remark 9.

SECTION IV - MUSCLE ATROPHY

RIGHT HIP	LEFT HIP
4A. Does the Veteran have muscle atrophy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	4A. Does the Veteran have muscle atrophy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide rationale:	4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide rationale:
4C. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.	4C. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.
<input type="checkbox"/> Right lower extremity (specify location of measurement such as "10cm above or below the hip"): _____ Circumference of more normal side: _____ cm Circumference of atrophied side: _____ cm	<input type="checkbox"/> Left lower extremity (specify location of measurement such as "10cm above or below the hip"): _____ Circumference of more normal side: _____ cm Circumference of atrophied side: _____ cm

SECTION V - ANKYLOSIS

RIGHT HIP

LEFT HIP

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

5A. Is there ankylosis of the hip and/or thigh? Yes No If yes, indicate the severity of ankylosis:

- Unfavorable, extremely unfavorable ankylosis, foot not reaching ground, crutches needed
- Intermediate, between favorable and unfavorable
- Favorable, in flexion at an angle between 20 and 40 degrees, and slight abduction or adduction

5A. Is there ankylosis of the hip and/or thigh? Yes No If yes, indicate the severity of ankylosis:

- Unfavorable, extremely unfavorable ankylosis, foot not reaching ground, crutches needed
- Intermediate, between favorable and unfavorable
- Favorable, in flexion at an angle between 20 and 40 degrees, and slight abduction or adduction

SECTION VI - FEMUR OR FLAIL HIP JOINT IMPAIRMENT

RIGHT HIP

LEFT HIP

Note: If impairment of the femur causes an associated knee disability, please complete the additional appropriate questionnaire.

6A. Does the Veteran have malunion or non union of femur, flail hip joint or leg length discrepancy? Yes No

- Fracture of shaft or neck (anatomical), with nonunion with loose motion (spiral or oblique fracture)
- Fracture of shaft or neck (anatomical), resulting in nonunion without loose motion; weight bearing preserved with aid of brace
- Fracture of surgical neck with false joint
- Malunion of the femur
- Flail hip joint

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 inch

For any leg length discrepancy, please describe the relationship to the conditions listed in the diagnosis section above:

6A. Does the Veteran have malunion or non union of femur, flail hip joint or leg length discrepancy? Yes No

- Fracture of shaft or neck (anatomical), with nonunion with loose motion (spiral or oblique fracture)
- Fracture of shaft or neck (anatomical), resulting in nonunion without loose motion; weight bearing preserved with aid of brace
- Fracture of surgical neck with false joint
- Malunion of the femur
- Flail hip joint

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: Left leg: _____ cm inch

For any leg length discrepancy, please describe the relationship to the conditions listed in the diagnosis section above:

SECTION VII - SURGICAL PROCEDURES

RIGHT HIP

LEFT HIP

7A. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):

- No surgery
- Hip joint resurfacing Date of surgery: _____
- Total hip joint replacement Date of surgery: _____

Total hip joint replacement residuals:

- None
- Moderately severe residuals of weakness, pain or limitation of motion
- Markedly severe residuals of weakness, pain or limitation of motion following implantation of prosthesis
- Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches
- Other, describe: _____

- Arthroscopic ligament repair Date of surgery: _____
- Other surgery not described (specify below): _____ Date of surgery: _____

Type of surgery: _____

7A. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):

- No surgery
- Hip joint resurfacing Date of surgery: _____
- Total hip joint replacement Date of surgery: _____

Total hip joint replacement residuals:

- None
- Moderately severe residuals of weakness, pain or limitation of motion
- Markedly severe residuals of weakness, pain or limitation of motion following implantation of prosthesis
- Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches
- Other, describe: _____

- Arthroscopic ligament repair Date of surgery: _____
- Other surgery not described (specify below): _____ Date of surgery: _____

Type of surgery: _____

SECTION VII - SURGICAL PROCEDURES (continued)

Residuals of arthroscopic or other hip surgery

Describe residuals:

Residuals of arthroscopic or other hip surgery

Describe residuals:

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

8A. 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)

Remark 10.

8B. 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 IX - ASSISTIVE DEVICES

9A. 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 the assistive devices used (check all that apply and indicate frequency):

- | | | | | |
|---|-------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Wheelchair | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Bracing for ambulation | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Crutches | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Cane(s) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Walker | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Other, describe: _____ | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |

9B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

Remark 10.

SECTION X - 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.

10A. Due to the Veterans hip or thigh 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 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

10B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

SECTION XI - 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.

11A. Have imaging studies been performed in conjunction with this examination? Yes No

11B. If yes, is degenerative or post traumatic arthritis documented? Yes No

Indicate side. Right Left Both

11C. If yes provide type of test or procedure, date and results (brief summary):

Remark 11:

11D. Are there any other significant 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):

Remark 11:

11E. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

Remark 11:

SECTION XII - 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.

12A. 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:

Remark 12:

SECTION XIII - REMARKS

13A. Remarks (if any please identify the section to which the remark pertains when appropriate):

Remark 13: All remarks are in the first appendix.

Remark 3. Diagnosis

~~The dates of diagnosis on this DBQ may differ from those found elsewhere, especially in C&P exams. The VA provides clear and unambiguous direction on this matter in a note on all of its DBQs: "Date of diagnosis can be. . . **AN APPROXIMATE DATE DETERMINED THROUGH RECORD REVIEW OR REPORTED HISTORY.**" It is common practice for C&P examiners to disregard this guidance along with the reported history from the Veteran. Instead, they often record the date when a medical record first contains a diagnosis despite no requirement whatsoever from the VA to have such a correspondence on the DBQs. In contrast, I have completed a careful record review and medical history to determine the approximate date of some observable sign or symptom that was the first manifestation of a disability. This date most accurately reflects the beginning of impairment. It often long precedes the date in a medical record, sometimes by many years. There are no additional diagnoses.~~

Remark 4. Medical history

See associated medical opinion for medical history.

Flare-ups: "Flare-ups interfere with all of my work and activities of daily living."

Repeated use over time: "Repeated use over time results in increased symptoms which interfere with walking, standing, kneeling, lifting, squatting, and stairs."

Remark 5. Functional loss

BILATERAL: Loss of ROM limits the ability to function normally because it degrades the operation of skeletal joints in all domains of normally expected capability in an occupational environment.

Remark 6. Active & Passive ROM

BILATERAL:

ACTIVE ROM: the major planes of hip motion (flexion, extension, abduction, and adduction) were measured in the standing position against strong manual resistance from the examiner's hands. The same was done for external and internal foot rotation, but in the supine position. This loaded the joints to best simulate function in a physically demanding, non-sedentary occupational environment. This also measured ROM under "**WEIGHT-BEARING**" conditions which is most sensibly done during examination of active ROM.

PASSIVE ROM: joint movements were measured only against the resistance of gravity - that is, without any manual resistance. This unloaded the joints to the maximum practical extent to best simulate function in a lighter-duty, sedentary occupational environment. This also measured ROM under "**NONWEIGHT-BEARING**" conditions which is most sensibly done during examination of passive ROM.

The proper examination of joint ROM is addressed further in an additional appendix.

Remark 7. Evidence of pain

BILATERAL: ROM was limited by pain. Loss of ROM limits the ability to function normally because it degrades the operation of skeletal joints in all domains of normally expected capability in an occupational environment. Crepitus in the hips is due to the claimed condition. The hips and associated soft tissues were moderately tender due to the claimed condition.

Remark 8. Estimated ROM after repeated use over time and during flare-ups

BILATERAL: The estimated ROM was based on all procurable evidence including my medical expertise as well as a thorough medical history incorporating lay statements from the Veteran.

Remark 9. Additional factors contributing to disability

BILATERAL: The selected factors from the above list contribute to disability by interfering with the normal mechanical functions of the body which then leads to difficulty with the basic activities of daily living.

Remark 10. Other findings, scars, and assistive devices

Not applicable.

Remark 11. Diagnostic testing

BILATERAL: Degenerative arthritis identified on x-ray studies. Reports enclosed. The abnormal imaging results are due to the claimed conditions.

Remark 12. Functional impact

BILATERAL: All occupational tasks (sedentary and non-sedentary) are impacted due to interference with walking, standing, kneeling, lifting, squatting, and stairs, as well as distraction and lack of concentration from chronic pain.

Remark 13. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on which it is based. In addition, I may possess the only existing evidence on a material issue if I unwittingly excluded it in an effort to keep my report focused. Due to my thoroughness, there is a high likelihood that for any given claim I would have information that is not otherwise readily obtainable or is simply absent from the evidence of record. In all cases, I would certainly want the opportunity to respond to any inquiry whatsoever with any information I have that might affect the probity of my work. Please also note that when "the missing information is relevant, factual, and objective – that is, not a matter of opinion" and "when a private medical report is the only evidence on a material issue, and material medical evidence can no longer be obtained as to that issue, yet clarification of a relevant, objective fact would render the private medical report~~

**KNEE AND LOWER LEG
DISABILITY BENEFITS QUESTIONNAIRE**

Name of Claimant/Veteran: <div style="background-color: black; width: 100%; height: 15px;"></div>	Claimant/Veteran's Social Security Number: <div style="background-color: black; width: 100%; height: 15px;"></div>	Date of Examination: <div style="background-color: black; width: 100%; height: 15px;"></div>
--	---	---

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

Remark 1.

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?

Remark 1.

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.

Remark 2.

SECTION I - DIAGNOSIS

1A. List the claimed conditions that pertain to this questionnaire: Knee condition.

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, 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:
<input type="checkbox"/> Knee strain	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Knee meniscal tear	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input checked="" type="checkbox"/> Knee anterior cruciate ligament tear	<input checked="" type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	S83.519S	Right: 1999 Left: _____
<input type="checkbox"/> Knee posterior cruciate ligament tear	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Patellar or quadriceps tendon rupture	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____

SECTION I - DIAGNOSIS (continued)

	Side affected:			ICD Code:	Date of diagnosis:		
	Right	Left	Both		Right:	Left:	
<input checked="" type="checkbox"/> Knee joint osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	M17.9	Right: 1999	Left: 2000	
<input type="checkbox"/> Knee joint ankylosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Knee fracture (including patellar fracture)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Stress fracture of tibia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Tibia and/or fibula fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Recurrent patellar dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Recurrent subluxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input checked="" type="checkbox"/> Knee instability	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M23.50	Right: 1999	Left: _____	
<input type="checkbox"/> Patellar instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Knee cartilage restoration surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Shin splints (if diagnosed with compartment syndrome complete the Muscles questionnaire in lieu of this questionnaire)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Patellofemoral pain syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Degenerative arthritis, other than post traumatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Arthritis, gonorrheal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Arthritis, pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Arthritis, streptococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Arthritis, syphilitic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Arthritis, rheumatoid (multi joints)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Post traumatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Arthritis, typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Other specified forms of arthropathy (excluding gout) (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Osteoporosis, residuals of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Osteomalacia, residuals of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Bones, neoplasm, benign	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Osteitis deformans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Myositis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Heterotopic ossification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Tendinopathy (select one if known)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Tendinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Tendinosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Tenosynovitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	
<input type="checkbox"/> Inflammatory other types (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Right: _____	Left: _____	

Other (specify) _____

Other diagnosis #1 _____

Side affected: Right Left Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

Other diagnosis #2 _____

Side affected: Right Left Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

Other diagnosis #3 _____

Side affected: Right Left Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

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

Remark 3. _____

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's knee and/or lower leg condition (brief summary):

Remark 4.

2B. Does the Veteran report flare ups of the knee and/or lower leg? Yes No If yes, document the Veteran's description of the flare ups he/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.

Remark 4.

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.

Remark 4.

2D. Does the Veteran report or have a history of instability or recurrent subluxation of the knee? Yes No If yes, document the Veteran's description of instability/ recurrent subluxation in his/her own words.

Remark 4.

2E. Does the Veteran report or have a history of frequent effusion of the knee? Yes No If yes, is the frequent effusion a result of a diagnosis in Section I? Describe below:

Remark 4.

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.

RIGHT KNEE	LEFT KNEE
3A. Initial ROM measurements	3A. Initial ROM measurements
<input type="checkbox"/> All Normal <input checked="" type="checkbox"/> Abnormal or outside of normal range <input type="checkbox"/> Unable to test <input type="checkbox"/> Not indicated	<input type="checkbox"/> All Normal <input checked="" type="checkbox"/> Abnormal or outside of normal range <input type="checkbox"/> Unable to test <input type="checkbox"/> Not indicated
If "Unable to test" or "Not indicated" please explain:	If "Unable to test" or "Not indicated" please explain:
If ROM is outside of "normal" range, but is normal for the Veteran (for reason other than a knee/lower leg condition, such as age, body habitus, neurologic disease), please describe:	If ROM is outside of "normal" range, but is normal for the Veteran (for reason other than a knee/lower leg condition, such as age, body habitus, neurologic disease), please describe:
If abnormal, does the range of motion itself contribute to a functional loss? (if yes, please explain) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If abnormal, does the range of motion itself contribute to a functional loss? (if yes, please explain) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Remark 5.	Remark 5.

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

RIGHT KNEE	LEFT KNEE
3A. Initial ROM measurements (continued)	3A. Initial ROM measurements (continued)
<p>Note: For any joint condition, examiners should address pain on both passive and active motion, and on both weight bearing and nonweight bearing. Examiners should also test the contralateral joint (unless medically contraindicated). If testing cannot be performed or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation must be given below. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).</p>	
Can testing be performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, provide an explanation:	Can testing be performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, provide an explanation:
If this is the unclaimed joint, is it: <input type="checkbox"/> Damaged <input type="checkbox"/> Undamaged	If this is the unclaimed joint, is it: <input type="checkbox"/> Damaged <input type="checkbox"/> Undamaged
If undamaged, range of motion testing must be conducted.	If undamaged, range of motion testing must be conducted.
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.
Flexion endpoint (140 degrees): <u>30</u> degrees	Flexion endpoint (140 degrees): <u>30</u> degrees
Extension endpoint (0 degrees): <u>15</u> degrees	Extension endpoint (0 degrees): <u>15</u> degrees
If noted on examination, which ROM exhibited pain (select all that apply):	If noted on examination, which ROM exhibited pain (select all that apply):
<input checked="" type="checkbox"/> Flexion <input checked="" type="checkbox"/> Extension	<input checked="" type="checkbox"/> Flexion <input checked="" type="checkbox"/> Extension
If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.	If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.
<u>30</u> Flexion degree endpoint (if different than above) <u>15</u> Extension degree endpoint (if different than above)	<u>30</u> Flexion degree endpoint (if different than above) <u>15</u> Extension degree endpoint (if different than above)
Remark 6.	Remark 6.
Passive Range of Motion Perform passive range of motion and provide the ROM values.	Passive Range of Motion Perform passive range of motion and provide the ROM values.
Flexion endpoint (140 degrees): <u>90</u> degrees <input type="checkbox"/> Same as active ROM	Flexion endpoint (140 degrees): <u>90</u> degrees <input type="checkbox"/> Same as active ROM
Extension endpoint (0 degrees): <u>0</u> degrees <input type="checkbox"/> Same as active ROM	Extension endpoint (0 degrees): <u>0</u> degrees <input type="checkbox"/> Same as active ROM
If noted on examination, which passive ROM exhibited pain (select all that apply):	If noted on examination, which passive ROM exhibited pain (select all that apply):
<input checked="" type="checkbox"/> Flexion <input checked="" type="checkbox"/> Extension	<input checked="" type="checkbox"/> Flexion <input checked="" type="checkbox"/> Extension
If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.	If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.
<u>90</u> Flexion degree endpoint (if different than above) <u>0</u> Extension degree endpoint (if different than above)	<u>90</u> Flexion degree endpoint (if different than above) <u>0</u> Extension degree endpoint (if different than above)
Remark 6.	Remark 6.
Is there evidence of pain? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes check all that apply.	Is there evidence of pain? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes check all that apply.
<input checked="" type="checkbox"/> weight bearing <input checked="" type="checkbox"/> nonweight bearing	<input checked="" type="checkbox"/> weight bearing <input checked="" type="checkbox"/> nonweight bearing
<input checked="" type="checkbox"/> active motion <input checked="" type="checkbox"/> passive motion <input type="checkbox"/> on rest/non movement	<input checked="" type="checkbox"/> active motion <input checked="" type="checkbox"/> passive motion <input type="checkbox"/> on rest/non movement
<input checked="" type="checkbox"/> causes functional loss (if checked describe in the comments box below) <input type="checkbox"/> does not result in/cause functional loss	<input checked="" type="checkbox"/> causes functional loss (if checked describe in the comments box below) <input type="checkbox"/> does not result in/cause functional loss
Comments:	Comments:
Remark 7.	Remark 7.

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

RIGHT KNEE	LEFT KNEE
3A. Initial ROM measurements (continued)	3A. Initial ROM measurements (continued)
Is there objective evidence of crepitus? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Is there objective evidence of crepitus? <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).	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).
Remark 7.	Remark 7.
3B. Observed repetitive use ROM	3B. Observed repetitive use ROM
Is the Veteran able to perform repetitive use testing with at least three repetitions? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:	Is the Veteran able to perform repetitive use testing with at least three repetitions? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:
Is there additional loss of function or range of motion after three repetitions? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Is there additional loss of function or range of motion after three repetitions? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If yes, please respond to the following after the completion of the three repetitions:	If yes, please respond to the following after the completion of the three repetitions:
Flexion endpoint (140 degrees): _____ degrees	Flexion endpoint (140 degrees): _____ degrees
Extension endpoint (0 degrees): _____ degrees	Extension endpoint (0 degrees): _____ degrees
Select factors that cause this functional loss: (check all that apply)	Select factors that cause this functional loss: (check all that apply)
<input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance	<input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance
<input type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input checked="" type="checkbox"/> N/A	<input type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input checked="" type="checkbox"/> N/A
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. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare ups even if not directly observed during a flare up and/or after repeated use over time.	
3C. Repeated use over time	3C. Repeated use over time
Is the Veteran being examined immediately after repeated use over time? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Is the Veteran being examined immediately after repeated use over time? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Select factors that cause this functional loss. (Check all that apply)	Select factors that cause this functional loss. (Check all that apply)
<input checked="" type="checkbox"/> Pain <input checked="" type="checkbox"/> Fatigability <input checked="" type="checkbox"/> Weakness <input checked="" type="checkbox"/> Lack of endurance	<input checked="" type="checkbox"/> Pain <input checked="" type="checkbox"/> Fatigability <input checked="" type="checkbox"/> Weakness <input checked="" type="checkbox"/> Lack of endurance
<input checked="" type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A	<input checked="" type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A
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.	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.
Flexion endpoint (140 degrees): <u>30</u> degrees	Flexion endpoint (140 degrees): <u>30</u> degrees
Extension endpoint (0 degrees): <u>15</u> degrees	Extension endpoint (0 degrees): <u>15</u> degrees
The examiner should provide the estimated range of motion 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.	The examiner should provide the estimated range of motion 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.)	Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)
Remark 8.	Remark 8.

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

RIGHT KNEE	LEFT KNEE
<p>3D. Flare ups</p> <p>Is the examination being conducted during a flare up? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare ups? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select factors that cause this functional loss. (Check all that apply)</p> <p><input checked="" type="checkbox"/> Pain <input checked="" type="checkbox"/> Fatigability <input checked="" type="checkbox"/> Weakness <input checked="" type="checkbox"/> Lack of endurance</p> <p><input checked="" type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A</p> <p>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.</p> <p>Flexion endpoint (140 degrees): <u>30</u> degrees</p> <p>Extension endpoint (0 degrees): <u>15</u> degrees</p> <p>The examiner should provide the estimated range of motion 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.</p> <p>Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)</p>	<p>3D. Flare ups</p> <p>Is the examination being conducted during a flare up? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare ups? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select factors that cause this functional loss. (Check all that apply)</p> <p><input checked="" type="checkbox"/> Pain <input checked="" type="checkbox"/> Fatigability <input checked="" type="checkbox"/> Weakness <input checked="" type="checkbox"/> Lack of endurance</p> <p><input checked="" type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A</p> <p>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.</p> <p>Flexion endpoint (140 degrees): <u>30</u> degrees</p> <p>Extension endpoint (0 degrees): <u>15</u> degrees</p> <p>The examiner should provide the estimated range of motion 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.</p> <p>Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)</p>
<p>Remark 8.</p>	<p>Remark 8.</p>

<p>3E. Additional factors contributing to disability</p> <p>In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:</p> <p><input type="checkbox"/> None <input checked="" type="checkbox"/> Interference with sitting</p> <p><input checked="" type="checkbox"/> Interference with standing <input type="checkbox"/> Swelling</p> <p><input checked="" type="checkbox"/> Disturbance of locomotion <input type="checkbox"/> Deformity</p> <p><input checked="" type="checkbox"/> Less movement than normal <input checked="" type="checkbox"/> More movement than normal (indicate if there is nonunion of fracture)</p> <p style="padding-left: 40px;"><input type="checkbox"/> nonunion of fracture</p> <p><input checked="" type="checkbox"/> Weakened movement <input type="checkbox"/> Atrophy of disuse</p> <p><input checked="" type="checkbox"/> Instability of station <input type="checkbox"/> Other, describe:</p> <p>Please describe additional contributing factors of disability:</p>	<p>3E. Additional factors contributing to disability</p> <p>In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:</p> <p><input type="checkbox"/> None <input checked="" type="checkbox"/> Interference with sitting</p> <p><input checked="" type="checkbox"/> Interference with standing <input type="checkbox"/> Swelling</p> <p><input checked="" type="checkbox"/> Disturbance of locomotion <input type="checkbox"/> Deformity</p> <p><input checked="" type="checkbox"/> Less movement than normal <input type="checkbox"/> More movement than normal (indicate if there is nonunion of fracture)</p> <p style="padding-left: 40px;"><input type="checkbox"/> nonunion of fracture</p> <p><input checked="" type="checkbox"/> Weakened movement <input type="checkbox"/> Atrophy of disuse</p> <p><input type="checkbox"/> Instability of station <input type="checkbox"/> Other, describe:</p> <p>Please describe additional contributing factors of disability:</p>
<p>Remark 9.</p>	<p>Remark 9.</p>

SECTION IV - MUSCLE ATROPHY

<p>4A. Does the Veteran have muscle atrophy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide rationale:</p>	<p>4A. Does the Veteran have muscle atrophy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide rationale:</p>
<p>Remark 10.</p>	<p>Remark 10.</p>

SECTION IV - MUSCLE ATROPHY (continued)

<p>RIGHT KNEE</p> <p>4C. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.</p> <p><input type="checkbox"/> Right lower extremity (specify location of measurement such as "10cm above or below the knee"):</p> <p>Remark 10. _____</p> <p>Circumference of more normal side: _____ cm Circumference of atrophied side: _____ cm</p>	<p>LEFT KNEE</p> <p>4C. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.</p> <p><input type="checkbox"/> Left lower extremity (specify location of measurement such as "10cm above or below the knee"):</p> <p>Remark 10. _____</p> <p>Circumference of more normal side: _____ cm Circumference of atrophied side: _____ cm</p>
---	---

SECTION V - ANKYLOSIS

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

<p>5A. Is there ankylosis of the knee and/or lower leg? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, indicate the severity of ankylosis:</p> <p><input type="checkbox"/> Favorable angle in full extension or in slight flexion between 0 and 10 degrees</p> <p><input type="checkbox"/> In flexion between 10 and 20 degrees</p> <p><input type="checkbox"/> In flexion between 20 and 45 degrees</p> <p><input type="checkbox"/> Extremely unfavorable, in flexion at an angle of 45 degrees or more</p> <p>5B. Indicate angle of ankylosis in degrees.</p> <p>_____ degrees <input type="checkbox"/> N/A no ankylosis of knee joint</p> <p>5C. If ankylosed, is there involvement of Muscle Group XIII (posterior thigh group, hamstring complex of 2 joint muscles: (1) biceps femoris; (2) semimembranosus; (3) semitendinosus)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the Muscle Injuries questionnaire.</p>	<p>5A. Is there ankylosis of the knee and/or lower leg? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, indicate the severity of ankylosis:</p> <p><input type="checkbox"/> Favorable angle in full extension or in slight flexion between 0 and 10 degrees</p> <p><input type="checkbox"/> In flexion between 10 and 20 degrees</p> <p><input type="checkbox"/> In flexion between 20 and 45 degrees</p> <p><input type="checkbox"/> Extremely unfavorable, in flexion at an angle of 45 degrees or more</p> <p>5B. Indicate angle of ankylosis in degrees.</p> <p>_____ degrees <input type="checkbox"/> N/A no ankylosis of knee joint</p> <p>5C. If ankylosed, is there involvement of Muscle Group XIII (posterior thigh group, hamstring complex of 2 joint muscles: (1) biceps femoris; (2) semimembranosus; (3) semitendinosus)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the Muscle Injuries questionnaire.</p>
--	--

SECTION VI - JOINT STABILITY

Note: For patellar instability, the patellofemoral complex consists of the quadriceps tendon, the patella, and the patellar tendon. A surgical procedure that does not involve repair of one or more patellofemoral components that contribute to the underlying instability shall not qualify as surgical repair for patellar instability (including but not limited to, arthroscopy to remove loose bodies and joint aspiration).

<p>6A. Is there recurrent subluxation or persistent instability? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6B. Is there or has there been a ligament tear (sprain)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, select one of the following.</p> <p><input type="checkbox"/> Complete ligament tear <input checked="" type="checkbox"/> Incomplete/partial ligament tear</p> <p>6C. Was the ligament tear repaired? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, select one of the following.</p> <p><input type="checkbox"/> Complete tear repair successful <input type="checkbox"/> Complete tear repair failed</p> <p>6D. Does the Veteran require a prescription (by a medical provider) of any of the following for ambulation? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, check all that apply.</p> <p><input type="checkbox"/> Cane(s) <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Brace(s)</p> <p>6E. Is there recurrent patellar instability? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>6F. Has the Veteran had surgical repair of the knee for patellar instability? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please describe:</p> <p>Remark 10. _____</p> <p>6G. Does the Veteran require a prescription (by a medical provider) of any of the following for ambulation with patellar instability? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, check all that apply.</p> <p><input type="checkbox"/> Cane(s) <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Brace(s)</p>	<p>6A. Is there recurrent subluxation or persistent instability? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>6B. Is there or has there been a ligament tear (sprain)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, select one of the following.</p> <p><input type="checkbox"/> Complete ligament tear <input type="checkbox"/> Incomplete/partial ligament tear</p> <p>6C. Was the ligament tear repaired? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, select one of the following.</p> <p><input type="checkbox"/> Complete tear repair successful <input type="checkbox"/> Complete tear repair failed</p> <p>6D. Does the Veteran require a prescription (by a medical provider) of any of the following for ambulation? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, check all that apply.</p> <p><input type="checkbox"/> Cane(s) <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Brace(s)</p> <p>6E. Is there recurrent patellar instability? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>6F. Has the Veteran had surgical repair of the knee for patellar instability? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please describe:</p> <p>Remark 10. _____</p> <p>6G. Does the Veteran require a prescription (by a medical provider) of any of the following for ambulation with patellar instability? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, check all that apply.</p> <p><input type="checkbox"/> Cane(s) <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Brace(s)</p>
--	--

SECTION VII - TIBIAL OR FIBULAR IMPAIRMENT

RIGHT KNEE	LEFT KNEE
<p>7A. Does the Veteran currently have or has the Veteran been diagnosed with a recurrent patellar dislocation, shin splints (medial tibial stress syndrome), stress fractures, or any other tibial or fibular impairment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If yes, indicate condition and complete the appropriate sections below):</p> <p><input type="checkbox"/> Stress fracture of the lower leg (If this affects ROM of the ankle, please complete the appropriate musculoskeletal questionnaire and ROM section)</p> <p>Describe current symptoms: Remark 10.</p> <p><input type="checkbox"/> Acquired and/or traumatic genu recurvatum with objectively demonstrated weakness and insecurity in weight bearing.</p> <p><input type="checkbox"/> Recurrent patellar dislocation</p> <p><input type="checkbox"/> "Shin Splints" (medial tibial stress syndrome MTSS) (indicate all treatment and symptoms below)</p> <p><input type="checkbox"/> treatment for less than 12 consecutive months</p> <p><input type="checkbox"/> unresponsive to shoe orthotics or other conservative treatment</p> <p><input type="checkbox"/> requiring treatment for 12 consecutive months or more</p> <p><input type="checkbox"/> responsive to surgery</p> <p><input type="checkbox"/> unresponsive to surgery</p> <p>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).</p> <p><input type="checkbox"/> Measurements: Right leg: _____ <input type="checkbox"/> cm <input type="checkbox"/> inch</p> <p>For any leg length discrepancy, please describe the relationship to the conditions listed in the diagnosis section above:</p> <p>Remark 10.</p>	<p>7A. Does the Veteran currently have or has the Veteran been diagnosed with a recurrent patellar dislocation, shin splints (medial tibial stress syndrome), stress fractures, or any other tibial or fibular impairment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If yes, indicate condition and complete the appropriate sections below):</p> <p><input type="checkbox"/> Stress fracture of the lower leg (If this affects ROM of the ankle, please complete the appropriate musculoskeletal questionnaire and ROM section)</p> <p>Describe current symptoms: Remark 10.</p> <p><input type="checkbox"/> Acquired and/or traumatic genu recurvatum with objectively demonstrated weakness and insecurity in weight bearing.</p> <p><input type="checkbox"/> Recurrent patellar dislocation</p> <p><input type="checkbox"/> "Shin Splints" (medial tibial stress syndrome MTSS) (indicate all treatment and symptoms below)</p> <p><input type="checkbox"/> treatment for less than 12 consecutive months</p> <p><input type="checkbox"/> unresponsive to shoe orthotics or other conservative treatment</p> <p><input type="checkbox"/> requiring treatment for 12 consecutive months or more</p> <p><input type="checkbox"/> responsive to surgery</p> <p><input type="checkbox"/> unresponsive to surgery</p> <p>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).</p> <p><input type="checkbox"/> Measurements: Left leg: _____ <input type="checkbox"/> cm <input type="checkbox"/> inch</p> <p>For any leg length discrepancy, please describe the relationship to the conditions listed in the diagnosis section above:</p> <p>Remark 10.</p>

SECTION VIII - MENISCAL CONDITIONS

<p>8A. Does the Veteran currently have or has the Veteran been diagnosed with a meniscus (semilunar cartilage) condition? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If yes, indicate severity and frequency of symptoms):</p> <p><input type="checkbox"/> No current symptoms <input type="checkbox"/> Meniscal dislocation</p> <p><input type="checkbox"/> Meniscal tear <input type="checkbox"/> Frequent episodes of joint "locking"</p> <p><input type="checkbox"/> Frequent episodes of joint pain <input type="checkbox"/> Frequent episodes of joint effusion</p> <p>For all checked boxes above, describe:</p> <p>Remark 11.</p>	<p>8A. Does the Veteran currently have or has the Veteran been diagnosed with a meniscus (semilunar cartilage) condition? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If yes, indicate severity and frequency of symptoms):</p> <p><input type="checkbox"/> No current symptoms <input type="checkbox"/> Meniscal dislocation</p> <p><input type="checkbox"/> Meniscal tear <input type="checkbox"/> Frequent episodes of joint "locking"</p> <p><input type="checkbox"/> Frequent episodes of joint pain <input type="checkbox"/> Frequent episodes of joint effusion</p> <p>For all checked boxes above, describe:</p> <p>Remark 11.</p>
--	--

SECTION IX - SURGICAL PROCEDURES

RIGHT KNEE	LEFT KNEE
<p>9A. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):</p> <p><input checked="" type="checkbox"/> No surgery</p> <p><input type="checkbox"/> Knee joint resurfacing Date of surgery: Remark 12.</p> <p><input type="checkbox"/> Total knee joint replacement Date of surgery: Remark 12.</p> <p>Total knee joint replacement residuals: <input type="checkbox"/> None <input type="checkbox"/> Intermediate degrees of residual weakness, pain, or limitation of motion</p> <p><input type="checkbox"/> Chronic residuals consisting of severe painful motion or weakness</p>	<p>9A. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):</p> <p><input checked="" type="checkbox"/> No surgery</p> <p><input type="checkbox"/> Knee joint resurfacing Date of surgery: Remark 12.</p> <p><input type="checkbox"/> Total knee joint replacement Date of surgery: Remark 12.</p> <p>Total knee joint replacement residuals: <input type="checkbox"/> None <input type="checkbox"/> Intermediate degrees of residual weakness, pain, or limitation of motion</p> <p><input type="checkbox"/> Chronic residuals consisting of severe painful motion or weakness</p>

SECTION IX - SURGICAL PROCEDURES (continued)

RIGHT KNEE	LEFT KNEE
<input type="checkbox"/> Other residuals, describe: _____ Remark 12. _____ <input type="checkbox"/> Meniscectomy Date of surgery: _____ Remark 12. _____ <input type="checkbox"/> Arthroscopic ligament repair Date of surgery: _____ Remark 12. _____ <input type="checkbox"/> Other surgery not described (specify below): _____ Date of surgery: _____ Remark 12. _____ Type of surgery: _____ Remark 12. _____ <input type="checkbox"/> Residual signs of symptoms due to meniscectomy, arthroscopic ligament repair or other knee surgery not described above: Describe residuals: <div style="border: 1px solid black; padding: 5px; min-height: 30px;">Remark 12.</div>	<input type="checkbox"/> Other residuals, describe: _____ Remark 12. _____ <input type="checkbox"/> Meniscectomy Date of surgery: _____ Remark 12. _____ <input type="checkbox"/> Arthroscopic ligament repair Date of surgery: _____ Remark 12. _____ <input type="checkbox"/> Other surgery not described (specify below): _____ Date of surgery: _____ Remark 12. _____ Type of surgery: _____ Remark 12. _____ <input type="checkbox"/> Residual signs of symptoms due to meniscectomy, arthroscopic ligament repair or other knee surgery not described above: Describe residuals: <div style="border: 1px solid black; padding: 5px; min-height: 30px;">Remark 12.</div>

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

10A. 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): _____

Remark 13. _____

10B. 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?
 Yes No If yes, also complete the appropriate dermatological questionnaire.

SECTION XI - ASSISTIVE DEVICES

11A. Does the Veteran use any assistive devices (other than those noted in Section VI) as a normal mode of locomotion, although occasional locomotion by other methods may be possible? Yes No

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

<input type="checkbox"/> Wheelchair	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Brace	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Crutches	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Cane(s)	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Walker	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Other, describe: _____	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant

11B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

Remark 13. _____

SECTION XII - 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.

12A. Due to the Veterans knee or lower leg condition(s), is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis (functions of the 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

12B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

Remark 13. _____

SECTION XIII - 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.

13A. Have imaging studies been performed in conjunction with this examination? Yes No

13B. If yes, is degenerative or post traumatic arthritis documented? Yes No

Indicate side. Right Left Both

13C. If yes provide type of test or procedure, date and results (brief summary):

Remark 14.

13D. Are there any other significant 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):

Remark 14.

13E. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

Remark 14.

SECTION XIV - 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.

14A. 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:

Remark 15.

SECTION XV - REMARKS

15A. Remarks (if any please identify the section to which the remark pertains when appropriate).

Remark 16.

All remarks are in the first appendix.

SECTION XVI - EXAMINER'S CERTIFICATION AND SIGNATURE

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

(Name, Psy.D, NP, PA C):

(Signature)

(License number and state):

Remark 3. Diagnosis

~~The dates of diagnosis on this DBQ may differ from those found elsewhere, especially in C&P exams. The VA provides clear and unambiguous direction on this matter in a note on all of its DBQs: "Date of diagnosis can be. . . **AN APPROXIMATE DATE DETERMINED THROUGH RECORD REVIEW OR REPORTED HISTORY.**" It is common practice for C&P examiners to disregard this guidance along with the reported history from the Veteran. Instead, they often record the date when a medical record first contains a diagnosis despite no requirement whatsoever from the VA to have such a correspondence on the DBQs. In contrast, I have completed a careful record review and medical history to determine the approximate date of some observable sign or symptom that was the first manifestation of a disability. This date most accurately reflects the beginning of impairment. It often long precedes the date in a medical record, sometimes by many years. There are no additional diagnoses.~~

Remark 4. Medical history

See associated medical opinion for medical history.

Flare-ups: "Flare-ups interfere with all of my work and activities of daily living."

Repeated use over time: "Repeated use over time results in increased symptoms which interfere with walking, standing, kneeling, lifting, squatting, and stairs."

Instability: "I have instability in my right knee. It will give out on me, or threaten to give out on me, on a regular basis."

Frequent effusion: Not applicable.

Remark 5. Functional loss

BILATERAL: Loss of ROM limits the ability to function normally because it degrades the operation of skeletal joints in all domains of normally expected capability in an occupational environment.

Remark 6. Active & passive ROM

BILATERAL:

ACTIVE ROM: flexion was measured in the standing position with 25 pound dumbbells held in each hand; extension was measured in the sitting position against strong manual resistance from the examiner's hands. This loaded the joints to best simulate actual function in a physically demanding, non-sedentary occupational environment. This also measured ROM under "**WEIGHT-BEARING**" conditions which is most sensibly done during examination of active ROM.

PASSIVE ROM: joint movements were measured only against the resistance of gravity - that is, without any dumbbells or manual resistance. This unloaded the joints to the maximum practical extent to best simulate function in a lighter-duty, sedentary occupational environment. This also measured ROM under "**NONWEIGHT-BEARING**" conditions which is most sensibly done during examination of passive ROM.

The proper examination of joint ROM is addressed further in an additional appendix.

Remark 7. Evidence of pain

BILATERAL: ROM was limited by pain. Loss of ROM limits the ability to function normally because it degrades the operation of skeletal joints in all domains of normally expected capability in an occupational environment. Crepitus in the knees is due to the claimed condition. The knees and associated soft tissues were moderately tender due to the claimed condition.

Remark 8. Estimated ROM after repeated use over time and during flare-ups

BILATERAL: The estimated ROM was based on all procurable evidence including my medical expertise as well as a thorough medical history incorporating lay statements from the Veteran.

Remark 9. Additional factors contributing to disability

BILATERAL: The selected factors from the above list contribute to disability by interfering with the normal mechanical functions of the body which then leads to difficulty with the basic activities of daily living.

Remark 10. Muscle atrophy and patellar instability surgery

Not applicable.

Remark 11. Meniscal conditions

Not applicable.

Remark 12. Surgical procedures

Not applicable.

Remark 13. Other findings, scars, assistive devices, and remaining effective function

Not applicable.

Remark 14. Diagnostic testing

BILATERAL: Degenerative arthritis identified on x-ray studies. Reports enclosed. The abnormal imaging results are due to the claimed condition.

Remark 15. Functional impact

BILATERAL: All occupational tasks (sedentary and non-sedentary) are impacted due to interference with walking, standing, kneeling, lifting, squatting, and stairs, as well as distraction and lack of concentration from chronic pain.

Remark 16. Clarifications

~~Please direct any requests regarding clarification or insufficiency of this private medical evidence directly to me. My contact information is listed below. I am readily available and would be quickly responsive to any such requests. I am best suited to answer such requests since, as the examining physician, I am naturally the most familiar with this report and the evidence on~~

10/13/2021

Independent Radiology Report

Patient: [REDACTED]

Study interpreted:

- Bilateral knee x-ray with AP, lateral, and sunrise views on 10/12/2021.

Comparison: None.

Findings:

Normal alignment. No acute fracture. Minimal bilateral patellofemoral osteoarthritic changes. Small superior patellar enthesophyte on the left. Soft tissues are unremarkable.

Impression:

Minimal patellofemoral osteoarthritic changes bilaterally.

Small superior patellar enthesophyte on the left.

[REDACTED]

[REDACTED] M.D.

Diagnostic Radiologist

[REDACTED]



