



HAND AND FINGERS
DISABILITY BENEFITS QUESTIONNAIRE

Name of Claimant/Veteran:

[Text input box for Name of Claimant/Veteran]

Claimant/Veteran's Social Security Number:

[Text input box for Social Security Number]

Date of Examination:

[Text input box for 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:

[Text input box for 'Other, please describe']

Are you a VA Healthcare provider? [ ] Yes [ ] No

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

Was the Veteran examined in person? [ ] Yes [ ] No

If no, how was the examination conducted?

[Text input box for 'If no, how was the examination conducted?']

EVIDENCE REVIEW

Evidence reviewed:

[ ] No records were reviewed

[ ] Records reviewed

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

[Large text input box for evidence reviewed]

DOMINANT HAND

Dominant hand: [ ] Right [ ] Left [ ] Ambidextrous

SECTION I - DIAGNOSIS

1A. List the claimed conditions that pertain to this questionnaire:

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:

Table with 5 rows of conditions (Depuytren's contracture, Trigger finger, Swan neck deformity, Boutonniere deformity, Mallet finger) and columns for Side affected (Right, Left, Both), ICD Code, and Date of diagnosis (Right, Left).

**SECTION I - DIAGNOSIS (continued)**

Side affected:

ICD Code:

Date of diagnosis:

<input type="checkbox"/> Gamekeeper's thumb	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>			
<input type="checkbox"/> Instability (chronic collateral ligament sprain)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Volar plate injury	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> MCP/PIP joint prosthetic replacement	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Ankylosis of digit joint(s), specify joint(s)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Degenerative arthritis, other than post-traumatic	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Arthritis, gonorrheal	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Arthritis, pneumococcal	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Arthritis, streptococcal	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Arthritis, syphilitic	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Arthritis, rheumatoid (multi-joint)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Post-traumatic arthritis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Arthritis, typhoid	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Other specified forms of arthropathy (excluding gout) (specify)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Osteoporosis, residuals of	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Osteomalacia, residuals of	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Bones, neoplasm, benign	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Osteitis deformans	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Gout	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Myositis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Heterotopic ossification	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Tendinopathy (select one if known)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Tendinitis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Tendinosis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Tenosynovitis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>
<input type="checkbox"/> Inflammatory other types (specify)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<hr/>		Right: <hr/>	Left: <hr/>

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: \_\_\_\_\_

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

\_\_\_\_\_

**SECTION II - MEDICAL HISTORY**

2A. Describe the history (including onset and course) of the Veteran's hand, finger or thumb condition (brief summary):

**SECTION II - MEDICAL HISTORY (continued)**

2B. Does the Veteran report flare-ups of the hand, finger or thumb?  Yes  No If yes, document the Veteran's description of the flare-ups he or she experiences, including the frequency, duration, characteristics, precipitating and alleviating factors, severity and/or extent of functional impairment he or she experiences during a flare-up of symptoms.

2C. Does the Veteran report having any functional loss or functional impairment of the joint or extremity being evaluated on this questionnaire, including but not limited to after repeated use over time?  Yes  No If yes, document the Veteran's description of functional loss or functional impairment in his/her own words.

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

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

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

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

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

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

RIGHT HAND	LEFT HAND
3A. Initial ROM measurements	3A. Initial ROM measurements
<input type="checkbox"/> All normal <input 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 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 hand/fingers 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 hand/fingers condition, such as age, body habitus, neurologic disease), please describe:
If abnormal, does the range of motion itself contribute to a functional loss? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please explain)	If abnormal, does the range of motion itself contribute to a functional loss? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please explain)
<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 type="checkbox"/> Yes <input type="checkbox"/> No If no, provide an explanation:	Can testing be performed? <input 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)**

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

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<p>Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"></td> <td style="width:15%;">MCP</td> <td style="width:15%;">PIP</td> <td style="width:15%;">DIP</td> </tr> <tr> <td>Index finger</td> <td></td> <td></td> <td></td> </tr> <tr> <td>    Flexion endpoint</td> <td>_____ 90 deg</td> <td>_____ 100 deg</td> <td>_____ 70 deg</td> </tr> <tr> <td>    Extension endpoint</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> </tr> <tr> <td>Long finger</td> <td>MCP</td> <td>PIP</td> <td>DIP</td> </tr> <tr> <td>    Flexion endpoint</td> <td>_____ 90 deg</td> <td>_____ 100 deg</td> <td>_____ 70 deg</td> </tr> <tr> <td>    Extension endpoint</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> </tr> <tr> <td>Ring finger</td> <td>MCP</td> <td>PIP</td> <td>DIP</td> </tr> <tr> <td>    Flexion endpoint</td> <td>_____ 90 deg</td> <td>_____ 100 deg</td> <td>_____ 70 deg</td> </tr> <tr> <td>    Extension endpoint</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> </tr> <tr> <td>Little finger</td> <td>MCP</td> <td>PIP</td> <td>DIP</td> </tr> <tr> <td>    Flexion endpoint</td> <td>_____ 90 deg</td> <td>_____ 100 deg</td> <td>_____ 70 deg</td> </tr> <tr> <td>    Extension endpoint</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> </tr> <tr> <td>Thumb</td> <td>MCP</td> <td>IP</td> <td></td> </tr> <tr> <td>    Flexion endpoint</td> <td>_____ 100 deg</td> <td>_____ 90 deg</td> <td></td> </tr> <tr> <td>    Extension endpoint</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> <td></td> </tr> </table>		MCP	PIP	DIP	Index finger				Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg	Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg	Long finger	MCP	PIP	DIP	Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg	Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg	Ring finger	MCP	PIP	DIP	Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg	Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg	Little finger	MCP	PIP	DIP	Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg	Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg	Thumb	MCP	IP		Flexion endpoint	_____ 100 deg	_____ 90 deg		Extension endpoint	_____ 0 deg	_____ 0 deg		<p>Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"></td> <td style="width:15%;">MCP</td> <td style="width:15%;">PIP</td> <td style="width:15%;">DIP</td> </tr> <tr> <td>Index finger</td> <td></td> <td></td> <td></td> </tr> <tr> <td>    Flexion endpoint</td> <td>_____ 90 deg</td> <td>_____ 100 deg</td> <td>_____ 70 deg</td> </tr> <tr> <td>    Extension endpoint</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> </tr> <tr> <td>Long finger</td> <td>MCP</td> <td>PIP</td> <td>DIP</td> </tr> <tr> <td>    Flexion endpoint</td> <td>_____ 90 deg</td> <td>_____ 100 deg</td> <td>_____ 70 deg</td> </tr> <tr> <td>    Extension endpoint</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> </tr> <tr> <td>Ring finger</td> <td>MCP</td> <td>PIP</td> <td>DIP</td> </tr> <tr> <td>    Flexion endpoint</td> <td>_____ 90 deg</td> <td>_____ 100 deg</td> <td>_____ 70 deg</td> </tr> <tr> <td>    Extension endpoint</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> </tr> <tr> <td>Little finger</td> <td>MCP</td> <td>PIP</td> <td>DIP</td> </tr> <tr> <td>    Flexion endpoint</td> <td>_____ 90 deg</td> <td>_____ 100 deg</td> <td>_____ 70 deg</td> </tr> <tr> <td>    Extension endpoint</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> </tr> <tr> <td>Thumb</td> <td>MCP</td> <td>IP</td> <td></td> </tr> <tr> <td>    Flexion endpoint</td> <td>_____ 100 deg</td> <td>_____ 90 deg</td> <td></td> </tr> <tr> <td>    Extension endpoint</td> <td>_____ 0 deg</td> <td>_____ 0 deg</td> <td></td> </tr> </table>		MCP	PIP	DIP	Index finger				Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg	Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg	Long finger	MCP	PIP	DIP	Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg	Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg	Ring finger	MCP	PIP	DIP	Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg	Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg	Little finger	MCP	PIP	DIP	Flexion endpoint	_____ 90 deg	_____ 100 deg	_____ 70 deg	Extension endpoint	_____ 0 deg	_____ 0 deg	_____ 0 deg	Thumb	MCP	IP		Flexion endpoint	_____ 100 deg	_____ 90 deg		Extension endpoint	_____ 0 deg	_____ 0 deg	
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**SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION (continued)**

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

RIGHT HAND	LEFT HAND																																																																																																								
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<p>Is there evidence of pain?    <input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes check all that apply.</p> <p><input type="checkbox"/> weight-bearing      <input type="checkbox"/> nonweight-bearing</p> <p><input type="checkbox"/> active motion      <input type="checkbox"/> passive motion      <input type="checkbox"/> on rest/non-movement</p> <p><input type="checkbox"/> causes functional loss (if checked describe in the comments box below)    <input type="checkbox"/> does not result in/cause functional loss</p> <p>Comments:</p>	<p>Is there evidence of pain?    <input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes check all that apply.</p> <p><input type="checkbox"/> weight-bearing      <input type="checkbox"/> nonweight-bearing</p> <p><input type="checkbox"/> active motion      <input type="checkbox"/> passive motion      <input type="checkbox"/> on rest/non-movement</p> <p><input type="checkbox"/> causes functional loss (if checked describe in the comments box below)    <input type="checkbox"/> does not result in/cause functional loss</p> <p>Comments:</p>																																																																																																								
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**SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION (continued)**

RIGHT HAND	LEFT HAND																														
3B. Observed repetitive use ROM (continued)	3B. Observed repetitive use ROM (continued)																														
If yes, please respond to the following after the completion of the three repetitions:																															
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Select factors that cause this functional loss: (check all that apply)	Select factors that cause this functional loss: (check all that apply)																														
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<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 or gap. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees or centimeters, as applicable) that reflect frequency, duration, and during flare-ups - even if not directly observed during a flare-up and/or after repeated use over time.</p>																															
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**SECTION IV - MUSCLE STRENGTH TESTING**

<b>RIGHT HAND</b>	<b>LEFT HAND</b>
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	
Hand grip: ____ /5	Hand grip: ____ /5
4B. If the Veteran has a reduction in muscle strength, is it due to the claimed condition in the diagnosis section? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide rationale:	4B. If the Veteran has a reduction in muscle strength, is it due to the claimed condition in the diagnosis section? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide rationale:
4C. Does the Veteran have muscle atrophy? <input type="checkbox"/> Yes <input type="checkbox"/> No	4C. Does the Veteran have muscle atrophy? <input type="checkbox"/> Yes <input type="checkbox"/> No
4D. 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:	4D. 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:
4E. For any muscle atrophy due to a diagnosis listed in Section 1, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.	4E. For any muscle atrophy due to a diagnosis listed in Section 1, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.
<input type="checkbox"/> Right upper extremity (specify location of measurement):  _____	<input type="checkbox"/> Left upper extremity (specify location of measurement):  _____
Circumference of more normal side: _____ cm      Circumference of atrophied side: _____ cm	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.

<b>RIGHT HAND</b>	<b>LEFT HAND</b>
5A. Complete this section if the Veteran has ankylosis of any thumb or finger joints. Indicate severity of ankylosis and side affected (check all that apply):	
Index finger - MCP joint <input type="checkbox"/> No ankylosis <input type="checkbox"/> MCP ankylosis	Index finger - MCP joint <input type="checkbox"/> No ankylosis <input type="checkbox"/> MCP ankylosis
If ankylosed, is there rotation of a bone? <input type="checkbox"/> Yes <input type="checkbox"/> No	If ankylosed, is there rotation of a bone? <input type="checkbox"/> Yes <input type="checkbox"/> No
If ankylosed, is there angulation of a bone? <input type="checkbox"/> Yes <input type="checkbox"/> No	If ankylosed, is there angulation of a bone? <input type="checkbox"/> Yes <input type="checkbox"/> No
If ankylosed, what is the position of ankylosis? <input type="checkbox"/> In extension <input type="checkbox"/> In full flexion <input type="checkbox"/> Other, _____ degrees of flexion	If ankylosed, what is the position of ankylosis? <input type="checkbox"/> In extension <input type="checkbox"/> In full flexion <input type="checkbox"/> Other, _____ degrees of flexion
Index finger - PIP joint <input type="checkbox"/> No ankylosis <input type="checkbox"/> PIP ankylosis	Index finger - PIP joint <input type="checkbox"/> No ankylosis <input type="checkbox"/> PIP ankylosis
If ankylosed, is there rotation of a bone? <input type="checkbox"/> Yes <input type="checkbox"/> No	If ankylosed, is there rotation of a bone? <input type="checkbox"/> Yes <input type="checkbox"/> No
If ankylosed, is there angulation of a bone? <input type="checkbox"/> Yes <input type="checkbox"/> No	If ankylosed, is there angulation of a bone? <input type="checkbox"/> Yes <input type="checkbox"/> No
If ankylosed, what is the position of ankylosis? <input type="checkbox"/> In extension <input type="checkbox"/> In full flexion <input type="checkbox"/> Other, _____ degrees of flexion	If ankylosed, what is the position of ankylosis? <input type="checkbox"/> In extension <input type="checkbox"/> In full flexion <input type="checkbox"/> Other, _____ degrees of flexion



**SECTION V - ANKYLOSIS (continued)**

RIGHT HAND

LEFT HAND

5B. Does the ankylosis result in limitation of motion of other digits or interference with overall function of the hand?  Yes  No If yes, please describe and provide rationale for your response

5B. Does the ankylosis result in limitation of motion of other digits or interference with overall function of the hand?  Yes  No If yes, please describe and provide rationale for your response

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

6A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the diagnosis section above.  Yes  No If yes, describe (brief summary):

6B. Does the Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis section above?  Yes  No If yes, also complete the appropriate dermatological questionnaire.

**SECTION VII - ASSISTIVE DEVICES**

7A. Does the Veteran use any assistive devices?  Yes  No

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

Brace Frequency of use:  Occasional  Regular  Constant

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

7B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

**SECTION VIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES**

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

8A. Due to the Veteran's hand, finger, or thumb condition(s), is there functional impairment of an extremity such that no effective functions remain other than that which would be equally well served by an amputation with prosthesis (functions of the upper extremity include grasping, manipulation, etc.)?

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

If yes, indicate extremities for which this applies:  Right upper  Left upper

8B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

**SECTION IX - DIAGNOSTIC TESTING**

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

9A. Have imaging studies been performed in conjunction with this examination?  Yes  No

9B. If yes, is degenerative or post-traumatic arthritis documented?  Yes  No

Indicate side:  Right  Left  Both

9C. Is degenerative or post-traumatic arthritis documented in multiple joints of the same hand, including thumb and fingers?  Yes  No

If yes, indicate side:  Right  Left  Both

**SECTION IX - DIAGNOSTIC TESTING (continued)**

9D. If yes (to 9B and/or 9C), provide type of test or procedure, date, and results (brief summary):

9E. 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):

9F. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

**SECTION X - FUNCTIONAL IMPACT**

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

10A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?  Yes  No If yes, describe the functional impact of each condition, providing one or more examples:

**SECTION XI - REMARKS**

11A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

**SECTION XII - EXAMINER'S CERTIFICATION AND SIGNATURE**

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

12A. Examiner's signature:

12B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

12C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

12D. Date Signed:

12E. Examiner's phone/fax numbers:

12F. National Provider Identifier (NPI) number:

12G. Medical license number and state:

12H. Examiner's address: