

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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

Note - The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the veteran's application. VA reserves the right to confirm the authenticity of ALL questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

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

Veteran/Claimant

Other: please describe

Are you a VA Healthcare provider?  Yes  No

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

Was the Veteran examined in person?  Yes  No

If no, how was the examination conducted?

**EVIDENCE REVIEW**

Evidence reviewed:

No records were reviewed

Records reviewed

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

**SECTION I - DIAGNOSIS**

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

YES  NO

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

INGUINAL HERNIA *(If checked, complete Section III.1)* ICD code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_  
 FEMORAL HERNIA *(If checked, complete Section III.2)* ICD code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_  
 VENTRAL HERNIA *(If checked, complete Section III.3)* ICD code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_  
 OTHER *(Specify)*:  
 OTHER DIAGNOSIS #1: \_\_\_\_\_ ICD code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_  
 \_\_\_\_\_ ICD code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_  
 OTHER DIAGNOSIS #2: \_\_\_\_\_ ICD code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_  
 \_\_\_\_\_ ICD code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

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

**SECTION II - MEDICAL HISTORY**

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

**SECTION III - HERNIA CONDITIONS**

1. INGUINAL HERNIA

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

Surgery performed *(Indicate side)*:  
 Right: Date and type of surgery: \_\_\_\_\_  
 Left: Date and type of surgery: \_\_\_\_\_  
 No previous surgery but hernia appears operable and remediable *(Indicate side)*:  Right:  Left:  
 Irremediable, provide reason: \_\_\_\_\_ *(Indicate side)*:  Right:  Left:  
 Inoperable, provide reason: \_\_\_\_\_ *(Indicate side)*:  Right:  Left:  
 Recurrent hernia following surgical repair *(Indicate status of postoperative recurrent hernia)*:  
 Recurrent hernia appears operable and remediable *(If checked, indicate side)*:  Right:  Left:  
 Irremediable, provide reason: \_\_\_\_\_ *(Indicate side)*:  Right:  Left:  
 Inoperable, provide reason: \_\_\_\_\_ *(Indicate side)*:  Right:  Left:

B. EXAM

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

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

Right:  Readily reducible  Not readily reducible  
Left:  Readily reducible  Not readily reducible

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

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

**SECTION III - HERNIA CONDITIONS (Continued)**

**2. FEMORAL HERNIA**

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

- Surgery performed (Indicate side):  
 Right: Date and type of surgery: \_\_\_\_\_  
 Left: Date and type of surgery: \_\_\_\_\_
- No previous surgery but hernia appears operable and remediable (Indicate side):  Right:  Left:
- Irremediable, provide reason: \_\_\_\_\_ (Indicate side):  Right:  Left:
- Inoperable, provide reason: \_\_\_\_\_ (Indicate side):  Right:  Left:
- Recurrent hernia following surgical repair (If checked, indicate status of postoperative recurrent hernia):  
 Recurrent hernia appears operable and remediable (Indicate side):  Right:  Left:  
 Irremediable, provide reason: \_\_\_\_\_ (Indicate side):  Right:  Left:  
 Inoperable, provide reason: \_\_\_\_\_ (Indicate side):  Right:  Left:

**B. EXAM**

- Right:  No hernia detected  No true hernia protrusion  Small hernia  Large hernia  
 Left:  No hernia detected  No true hernia protrusion  Small hernia  Large hernia

**C. ABILITY TO BE REDUCED**

- Right:  Readily reducible  Not readily reducible  
 Left:  Readily reducible  Not readily reducible

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

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

**3. VENTRAL HERNIA**

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

- Surgery performed  
 Date and type of surgery: \_\_\_\_\_
- No previous surgery but hernia appears operable and remediable
- Irremediable, provide reason: \_\_\_\_\_
- Inoperable, provide reason: \_\_\_\_\_
- Recurrent hernia following surgical repair (Indicate status of postoperative recurrent hernia):  
 Recurrent hernia appears operable and remediable  
 Irremediable, provide reason: \_\_\_\_\_  
 Inoperable, provide reason: \_\_\_\_\_

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

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

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

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

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

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

1A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES  NO

IF YES, DESCRIBE (*brief summary*):

1B. DOES THE VETERAN HAVE ANY SCARS (*surgical or otherwise*) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES  NO

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

YES  NO

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

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

LOCATION: \_\_\_\_\_ MEASUREMENTS: length \_\_\_\_\_ cm X width \_\_\_\_\_ cm.

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

1C. COMMENTS, IF ANY:

**2. DIAGNOSTIC TESTING**

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

ARE THERE ANY SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

YES  NO (*If "Yes," provide type of test or procedure, date and results - brief summary*):

**3. FUNCTIONAL IMPACT**

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

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

**4. REMARKS**

REMARKS (*If any*):

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

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

5A. Examiner's signature:

5B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

5C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

5D. Date Signed:

5E. Examiner's phone/fax numbers:

5F. National Provider Identifier (NPI) number:

5G. Medical license number and state:

5H. Examiner's address: