

KNEE AND LOWER LEG DISABILITY BENEFITS QUESTIONNAIRE

Name of Claimant/Veteran: <div style="border: 1px solid black; height: 20px; width: 95%;"></div>	Claimant/Veteran's Social Security Number: <div style="border: 1px solid black; height: 20px; width: 95%;"></div>	Date of Examination: <div style="border: 1px solid black; height: 20px; width: 95%;"></div>
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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. 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:
<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 type="checkbox"/> Knee anterior cruciate ligament tear	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ 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:	
	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Knee joint osteoarthritis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Knee joint ankylosis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Knee fracture (including patellar fracture)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Stress fracture of tibia	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Tibia and/or fibula fracture	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Recurrent patellar dislocation	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Recurrent subluxation	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Knee instability	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Patellar instability	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Knee cartilage restoration surgery	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Shin splints (if diagnosed with compartment syndrome complete the Muscles questionnaire in lieu of this questionnaire)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Patellofemoral pain syndrome	<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-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: _____
<hr/>						
<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: _____
<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 knee conditions, list using above format:						

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's knee and/or lower leg condition (brief summary):

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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.

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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.

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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.

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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:

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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 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 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 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 type="checkbox"/> Yes <input type="checkbox"/> No

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

<p>RIGHT KNEE</p>	<p>LEFT KNEE</p>
<p>3A. Initial ROM measurements (continued)</p>	<p>3A. Initial ROM measurements (continued)</p>
<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>	
<p>Can testing be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide an explanation:</p> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> <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>Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values.</p> <p>Flexion endpoint (140 degrees): _____ degrees</p> <p>Extension endpoint (0 degrees): _____ degrees</p> <p>If noted on examination, which ROM exhibited pain (select all that apply):</p> <p><input type="checkbox"/> Flexion <input type="checkbox"/> Extension</p> <p>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.</p> <p>_____ Flexion degree endpoint (if different than above) _____ Extension degree endpoint (if different than above)</p> <div style="border: 1px solid black; height: 60px; margin-top: 10px;"></div>	<p>Can testing be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide an explanation:</p> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> <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>Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values.</p> <p>Flexion endpoint (140 degrees): _____ degrees</p> <p>Extension endpoint (0 degrees): _____ degrees</p> <p>If noted on examination, which ROM exhibited pain (select all that apply):</p> <p><input type="checkbox"/> Flexion <input type="checkbox"/> Extension</p> <p>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.</p> <p>_____ Flexion degree endpoint (if different than above) _____ Extension degree endpoint (if different than above)</p> <div style="border: 1px solid black; height: 60px; margin-top: 10px;"></div>
<p>Passive Range of Motion - Perform passive range of motion and provide the ROM values.</p> <p>Flexion endpoint (140 degrees): _____ degrees <input type="checkbox"/> Same as active ROM</p> <p>Extension endpoint (0 degrees): _____ degrees <input type="checkbox"/> Same as active ROM</p> <p>If noted on examination, which passive ROM exhibited pain (select all that apply):</p> <p><input type="checkbox"/> Flexion <input type="checkbox"/> Extension</p> <p>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.</p> <p>_____ Flexion degree endpoint (if different than above) _____ Extension degree endpoint (if different than above)</p> <div style="border: 1px solid black; height: 60px; margin-top: 10px;"></div>	<p>Passive Range of Motion - Perform passive range of motion and provide the ROM values.</p> <p>Flexion endpoint (140 degrees): _____ degrees <input type="checkbox"/> Same as active ROM</p> <p>Extension endpoint (0 degrees): _____ degrees <input type="checkbox"/> Same as active ROM</p> <p>If noted on examination, which passive ROM exhibited pain (select all that apply):</p> <p><input type="checkbox"/> Flexion <input type="checkbox"/> Extension</p> <p>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.</p> <p>_____ Flexion degree endpoint (if different than above) _____ Extension degree endpoint (if different than above)</p> <div style="border: 1px solid black; height: 60px; margin-top: 10px;"></div>
<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> <div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div>	<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> <div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div>

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>Is there objective evidence of crepitus? <input 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 type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain. Include location, severity, and relationship to condition(s).</p>	<p>Is there objective evidence of crepitus? <input 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 type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain. Include location, severity, and relationship to condition(s).</p>
3B. Observed repetitive use ROM	3B. Observed repetitive use ROM
<p>Is the Veteran able to perform repetitive-use testing with at least three repetitions? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:</p>	<p>Is the Veteran able to perform repetitive-use testing with at least three repetitions? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:</p>
<p>Is there additional loss of function or range of motion after three repetitions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please respond to the following after the completion of the three repetitions:</p> <p>Flexion endpoint (140 degrees): _____ degrees</p> <p>Extension endpoint (0 degrees): _____ degrees</p> <p>Select factors that cause this functional loss: (check all that apply)</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A</p>	<p>Is there additional loss of function or range of motion after three repetitions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please respond to the following after the completion of the three repetitions:</p> <p>Flexion endpoint (140 degrees): _____ degrees</p> <p>Extension endpoint (0 degrees): _____ degrees</p> <p>Select factors that cause this functional loss: (check all that apply)</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A</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>	
3C. Repeated use over time	3C. Repeated use over time
<p>Is the Veteran being examined immediately after repeated use over time? <input type="checkbox"/> Yes <input 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 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"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A</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> <p>Flexion endpoint (140 degrees): _____ degrees</p> <p>Extension endpoint (0 degrees): _____ 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>Is the Veteran being examined immediately after repeated use over time? <input type="checkbox"/> Yes <input 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 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"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A</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> <p>Flexion endpoint (140 degrees): _____ degrees</p> <p>Extension endpoint (0 degrees): _____ 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>

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 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 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"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance</p> <p><input 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): _____ degrees</p> <p>Extension endpoint (0 degrees): _____ 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 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 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"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance</p> <p><input 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): _____ degrees</p> <p>Extension endpoint (0 degrees): _____ 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>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 type="checkbox"/> Interference with sitting</p> <p><input type="checkbox"/> Interference with standing <input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Disturbance of locomotion <input type="checkbox"/> Deformity</p> <p><input 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 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>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 type="checkbox"/> Interference with sitting</p> <p><input type="checkbox"/> Interference with standing <input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Disturbance of locomotion <input type="checkbox"/> Deformity</p> <p><input 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 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>
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SECTION IV - MUSCLE ATROPHY

<p>4A. Does the Veteran have muscle atrophy? <input type="checkbox"/> Yes <input 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 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>
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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> <hr style="width:80%; margin-left:0;"/> <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> <hr style="width:80%; margin-left:0;"/> <p>Circumference of more normal side: _____ cm Circumference of atrophied side: _____ cm</p>
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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 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 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>
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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 type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6B. Is there or has there been a ligament tear (sprain)? <input type="checkbox"/> Yes <input 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 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 type="checkbox"/> No</p> <p>6B. Is there or has there been a ligament tear (sprain)? <input type="checkbox"/> Yes <input 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 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 type="checkbox"/> No</p> <p>6F. Has the Veteran had surgical repair of the knee for patellar instability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:</p> <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>	<p>6E. Is there recurrent patellar instability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6F. Has the Veteran had surgical repair of the knee for patellar instability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:</p> <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>
<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 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>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 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 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: _____</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>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 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: _____</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>

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 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>8A. Does the Veteran currently have or has the Veteran been diagnosed with a meniscus (semilunar cartilage) condition? <input type="checkbox"/> Yes <input 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>
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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 type="checkbox"/> No surgery</p> <p><input type="checkbox"/> Knee joint resurfacing Date of surgery: _____</p> <p><input type="checkbox"/> Total knee joint replacement Date of surgery: _____</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 type="checkbox"/> No surgery</p> <p><input type="checkbox"/> Knee joint resurfacing Date of surgery: _____</p> <p><input type="checkbox"/> Total knee joint replacement Date of surgery: _____</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: _____ <input type="checkbox"/> Meniscectomy Date of surgery: _____ <input type="checkbox"/> Arthroscopic ligament repair Date of surgery: _____ <input type="checkbox"/> Other surgery not described (specify below): _____ Date of surgery: _____ Type of surgery: _____ <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; height: 40px; width: 100%;"></div>	<input type="checkbox"/> Other residuals, describe: _____ <input type="checkbox"/> Meniscectomy Date of surgery: _____ <input type="checkbox"/> Arthroscopic ligament repair Date of surgery: _____ <input type="checkbox"/> Other surgery not described (specify below): _____ Date of surgery: _____ Type of surgery: _____ <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; height: 40px; width: 100%;"></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): _____

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.

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):

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):

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):

13E. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

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:

SECTION XV - REMARKS

15A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

SECTION XVI - EXAMINER'S CERTIFICATION AND SIGNATURE

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

16A. Examiner's signature:

16B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

16C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

16D. Date Signed:

16E. Examiner's phone/fax numbers:

16F. National Provider Identifier (NPI) number:

16. Medical license number and state:

16H. Examiner's address: