



SHOULDER AND ARM CONDITIONS
DISABILITY BENEFITS QUESTIONNAIRE

Name of Claimant/Veteran:

[Empty text box for Name of Claimant/Veteran]

Claimant/Veteran's Social Security Number:

[Empty text box for Social Security Number]

Date of Examination:

[Empty text 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:

[Empty text 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?

[Empty text 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.

[Empty text box for evidence review details]

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)

Table with columns: Side affected (Right, Left, Both), ICD Code, Date of diagnosis (Right, Left). Rows include: Shoulder strain, Shoulder impingement syndrome, Bicipital tendonitis, Bicipital tendon tear, Rotator cuff tendonitis.

**SECTION I - DIAGNOSIS (continued)**

	Side affected:			ICD Code:	Date of diagnosis:		
	Right	Left	Both		Right:	Left:	
<input type="checkbox"/> Rotator cuff tear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Labral tear, including SLAP (superior labral anterior-posterior lesion)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Subacromial/subdeltoid bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Glenohumeral joint osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Acromioclavicular joint osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Ankylosis of glenohumeral articulations (shoulder joint)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Glenohumeral joint instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Glenohumeral joint dislocation/recurrent dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Shoulder joint replacement (total shoulder arthroplasty/hemiarthroplasty)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Acromioclavicular joint separation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Degenerative arthritis, other than post-traumatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Arthritis, gonorrheal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Arthritis, pneumococcic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Arthritis, streptococcic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Arthritis, syphilitic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Arthritis, rheumatoid (multi-joints)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Post-traumatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Arthritis, typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Other specified forms of arthropathy (excluding gout) (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<hr/>							
<input type="checkbox"/> Osteoporosis, residuals of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Osteomalacia, residuals of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Bones, neoplasm, benign	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Osteitis deformans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Myositis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Heterotopic ossification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Tendinopathy (select one if known)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Tendinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Tendinosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Tenosynovitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/> Inflammatory - other types (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<hr/>							
<input type="checkbox"/> Other (specify)	_____						
Other diagnosis #1	_____						
Side affected:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	ICD Code: _____	Date of diagnosis:	Right: _____	Left: _____
Other diagnosis #2	_____						
Side affected:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	ICD Code: _____	Date of diagnosis:	Right: _____	Left: _____
If there are additional diagnoses that pertain to shoulder and/or arm conditions, list using above format:	_____						

**SECTION II - MEDICAL HISTORY**

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

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

2B. Does the Veteran report flare-ups of the shoulder and/or arm?  Yes  No

If yes, document the Veteran's description of the flare-ups he or she experiences, including the frequency, duration, characteristics, precipitating and alleviating factors, severity and/or extent of functional impairment he or she experiences during a flare-up of symptoms:

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.

Right shoulder	Left shoulder
<p>3A. Initial ROM measurements</p> <p><input type="checkbox"/> All normal                      <input type="checkbox"/> Abnormal or outside of normal range</p> <p><input type="checkbox"/> Unable to test                      <input type="checkbox"/> Not indicated</p> <p>If "Unable to test" or "Not indicated" please explain:</p> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> <p>If ROM is outside of "normal" range, but is normal for the Veteran (for reason other than a shoulder/arm condition, such as age, body habitus, neurologic disease), please describe:</p> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> <p>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</p> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>	<p>3A. Initial ROM measurements</p> <p><input type="checkbox"/> All normal                      <input type="checkbox"/> Abnormal or outside of normal range</p> <p><input type="checkbox"/> Unable to test                      <input type="checkbox"/> Not indicated</p> <p>If "Unable to test" or "Not indicated" please explain:</p> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> <p>If ROM is outside of "normal" range, but is normal for the Veteran (for reason other than a shoulder/arm condition, such as age, body habitus, neurologic disease), please describe:</p> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div> <p>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</p> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>
<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>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>

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

**3A. Initial ROM measurements (continued)**

Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values.

Flexion endpoint (180 degrees): \_\_\_\_\_ degrees

Abduction endpoint (180 degrees): \_\_\_\_\_ degrees

Internal rotation endpoint (90 degrees): \_\_\_\_\_ degrees

External rotation endpoint (90 degrees): \_\_\_\_\_ degrees

If noted on examination, which ROM exhibited pain? (select all that apply):

- Flexion                       Internal rotation  
 Abduction                       External rotation

If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.

\_\_\_\_\_ Flexion degree endpoint (if different than above)  
 \_\_\_\_\_ Abduction degree endpoint (if different than above)  
 \_\_\_\_\_ Internal rotation degree endpoint (if different than above)  
 \_\_\_\_\_ External rotation degree endpoint (if different than above)

**3A. Initial ROM measurements (continued)**

Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values.

Flexion endpoint (180 degrees): \_\_\_\_\_ degrees

Abduction endpoint (180 degrees): \_\_\_\_\_ degrees

Internal rotation endpoint (90 degrees): \_\_\_\_\_ degrees

External rotation endpoint (90 degrees): \_\_\_\_\_ degrees

If noted on examination, which ROM exhibited pain? (select all that apply):

- Flexion                       Internal rotation  
 Abduction                       External rotation

If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.

\_\_\_\_\_ Flexion degree endpoint (if different than above)  
 \_\_\_\_\_ Abduction degree endpoint (if different than above)  
 \_\_\_\_\_ Internal rotation degree endpoint (if different than above)  
 \_\_\_\_\_ External rotation degree endpoint (if different than above)

Passive Range of Motion - Perform passive ROM and provide the ROM values.

Flexion endpoint (180 degrees): \_\_\_\_\_ degrees  Same as active ROM

Abduction endpoint (180 degrees): \_\_\_\_\_ degrees  Same as active ROM

Internal rotation endpoint (90 degrees): \_\_\_\_\_ degrees  Same as active ROM

External rotation endpoint (90 degrees): \_\_\_\_\_ degrees  Same as active ROM

If noted on examination, which ROM exhibited pain? (select all that apply):

- Flexion                       Internal rotation  
 Abduction                       External rotation

If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.

\_\_\_\_\_ Flexion degree endpoint (if different than above)  
 \_\_\_\_\_ Abduction degree endpoint (if different than above)  
 \_\_\_\_\_ Internal rotation degree endpoint (if different than above)  
 \_\_\_\_\_ External rotation degree endpoint (if different than above)

Passive Range of Motion - Perform passive ROM and provide the ROM values.

Flexion endpoint (180 degrees): \_\_\_\_\_ degrees  Same as active ROM

Abduction endpoint (180 degrees): \_\_\_\_\_ degrees  Same as active ROM

Internal rotation endpoint (90 degrees): \_\_\_\_\_ degrees  Same as active ROM

External rotation endpoint (90 degrees): \_\_\_\_\_ degrees  Same as active ROM

If noted on examination, which ROM exhibited pain? (select all that apply):

- Flexion                       Internal rotation  
 Abduction                       External rotation

If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.

\_\_\_\_\_ Flexion degree endpoint (if different than above)  
 \_\_\_\_\_ Abduction degree endpoint (if different than above)  
 \_\_\_\_\_ Internal rotation degree endpoint (if different than above)  
 \_\_\_\_\_ External rotation degree endpoint (if different than above)

Is there evidence of pain?  Yes  No If yes check all that apply.

- Weight-bearing                       Nonweight-bearing  
 Active motion                       Passive motion  
 On rest/non-movement                       Does not result in/cause functional loss  
 Causes functional loss (if checked describe in the comments box below)

Is there evidence of pain?  Yes  No If yes check all that apply.

- Weight-bearing                       Nonweight-bearing  
 Active motion                       Passive motion  
 On rest/non-movement                       Does not result in/cause functional loss  
 Causes functional loss (if checked describe in the comments box below)

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

<p>3A. Initial ROM measurements (continued)</p> <p>Right shoulder</p> <p>Comments:</p> <div style="border: 1px solid black; height: 80px; margin-bottom: 5px;"></div> <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> <div style="border: 1px solid black; height: 50px; margin-top: 5px;"></div>	<p>3A. Initial ROM measurements (continued)</p> <p>Left shoulder</p> <p>Comments:</p> <div style="border: 1px solid black; height: 80px; margin-bottom: 5px;"></div> <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> <div style="border: 1px solid black; height: 50px; margin-top: 5px;"></div>
<p>3B. Observed repetitive use ROM</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> <div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div> <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 (180 degrees): _____ degrees</p> <p>Abduction endpoint (180 degrees): _____ degrees</p> <p>Internal rotation endpoint (90 degrees): _____ degrees</p> <p>External rotation endpoint (90 degrees): _____ degrees</p> <p>Select factors that cause this functional loss (check all that apply):</p> <p><input type="checkbox"/> N/A <input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination</p> <p><input type="checkbox"/> Other _____</p>	<p>3B. Observed repetitive use ROM</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> <div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div> <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 (180 degrees): _____ degrees</p> <p>Abduction endpoint (180 degrees): _____ degrees</p> <p>Internal rotation endpoint (90 degrees): _____ degrees</p> <p>External rotation endpoint (90 degrees): _____ degrees</p> <p>Select factors that cause this functional loss (check all that apply):</p> <p><input type="checkbox"/> N/A <input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination</p> <p><input type="checkbox"/> Other _____</p>
<p>Note: When pain is associated with movement, the examiner must give a statement on whether pain could significantly limit functional ability during flare-ups and/or after repeated use over time in terms of additional loss of range of motion. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare-ups - even if not directly observed during a flare-up and/or after repeated use over time.</p>	
<p>3C. Repeated use over time</p> <p>Is the Veteran being examined immediately after repeated use over time? <input type="checkbox"/> Yes <input 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"/> N/A <input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination</p> <p><input type="checkbox"/> Other _____</p>	<p>3C. Repeated use over time</p> <p>Is the Veteran being examined immediately after repeated use over time? <input type="checkbox"/> Yes <input 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"/> N/A <input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination</p> <p><input type="checkbox"/> Other _____</p>

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

<p>3C.Repeated use over time (continued)</p> <p><b>Right shoulder</b></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 (180 degrees): _____ degrees</p> <p>Abduction endpoint (180 degrees): _____ degrees</p> <p>Internal rotation endpoint (90 degrees): _____ degrees</p> <p>External rotation endpoint (90 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 here. (Must be specific to the case and based on all procurable evidence.)</p>	<p>3C.Repeated use over time (continued)</p> <p><b>Left shoulder</b></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 (180 degrees): _____ degrees</p> <p>Abduction endpoint (180 degrees): _____ degrees</p> <p>Internal rotation endpoint (90 degrees): _____ degrees</p> <p>External rotation endpoint (90 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 here. (Must be specific to the case and based on all procurable evidence.)</p>
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<p><b>3D. Flare-ups</b></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"/> N/A    <input type="checkbox"/> Pain    <input type="checkbox"/> Fatigability    <input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Lack of endurance    <input type="checkbox"/> Incoordination</p> <p><input type="checkbox"/> Other _____</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 (180 degrees): _____ degrees</p> <p>Abduction endpoint (180 degrees): _____ degrees</p> <p>Internal rotation endpoint (90 degrees): _____ degrees</p> <p>External rotation endpoint (90 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 here. (Must be specific to the case and based on all procurable evidence.)</p>	<p><b>3D. Flare-ups</b></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"/> N/A    <input type="checkbox"/> Pain    <input type="checkbox"/> Fatigability    <input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Lack of endurance    <input type="checkbox"/> Incoordination</p> <p><input type="checkbox"/> Other _____</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 (180 degrees): _____ degrees</p> <p>Abduction endpoint (180 degrees): _____ degrees</p> <p>Internal rotation endpoint (90 degrees): _____ degrees</p> <p>External rotation endpoint (90 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 here. (Must be specific to the case and based on all procurable evidence.)</p>
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**SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION (continued)**

<p>3E. Additional factors contributing to disability</p> <p>In addition to those addressed above, are there additional contributing factors of disability? 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</p> <p><input type="checkbox"/> Weakened movement            <input type="checkbox"/> Atrophy of disuse</p> <p><input type="checkbox"/> Instability of station</p> <p><input type="checkbox"/> Other, describe: <input style="width: 150px;" type="text"/></p> <p>Please describe additional contributing factors of disability here:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	<p>3E. Additional factors contributing to disability</p> <p>In addition to those addressed above, are there additional contributing factors of disability? 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</p> <p><input type="checkbox"/> Weakened movement            <input type="checkbox"/> Atrophy of disuse</p> <p><input type="checkbox"/> Instability of station</p> <p><input type="checkbox"/> Other, describe: <input style="width: 150px;" type="text"/></p> <p>Please describe additional contributing factors of disability here:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
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**SECTION IV - MUSCLE ATROPHY**

<p><b>Right shoulder</b></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> <div style="border: 1px solid black; height: 60px; width: 100%;"></div> <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 upper extremity (specify location of measurement such as "10cm above the anterior elbow crease" here):</p> <p>_____</p> <p>Circumference of more normal side: _____ cm      Circumference of atrophied side: _____ cm</p>	<p><b>Left shoulder</b></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> <div style="border: 1px solid black; height: 60px; width: 100%;"></div> <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 upper extremity (specify location of measurement such as "10cm above the anterior elbow crease" here):</p> <p>_____</p> <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 scapulohumeral (glenohumeral) articulation (shoulder joint) - (i.e., the scapula and humerus move as one piece)?    <input type="checkbox"/> Yes    <input type="checkbox"/> No  If yes, indicate the severity of the ankylosis:</p> <p><input type="checkbox"/> Ankylosis in abduction up to 60 degrees; can reach mouth and head (favorable ankylosis)</p> <p><input type="checkbox"/> Ankylosis in abduction between favorable and unfavorable (intermediate ankylosis)</p> <p><input type="checkbox"/> Ankylosis in abduction at 25 degrees or less from side (unfavorable ankylosis)</p> <p>5B. Indicate angle of ankylosis in degrees of abduction: _____ degrees</p> <p>5C. If ankylosed, is there involvement of Muscle Group I (trapezius, levator scapulae, serratus magnus) and II (pectoralis major II (costosternal), latissimus dorsi and teres major, pectoralis minor; rhomboid)?    <input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes, complete the Muscle Injuries questionnaire.</p>	<p>5A. Is there ankylosis of the scapulohumeral (glenohumeral) articulation (shoulder joint) - (i.e., the scapula and humerus move as one piece)?    <input type="checkbox"/> Yes    <input type="checkbox"/> No  If yes, indicate the severity of the ankylosis:</p> <p><input type="checkbox"/> Ankylosis in abduction up to 60 degrees; can reach mouth and head (favorable ankylosis)</p> <p><input type="checkbox"/> Ankylosis in abduction between favorable and unfavorable (intermediate ankylosis)</p> <p><input type="checkbox"/> Ankylosis in abduction at 25 degrees or less from side (unfavorable ankylosis)</p> <p>5B. Indicate angle of ankylosis in degrees of abduction: _____ degrees</p> <p>5C. If ankylosed, is there involvement of Muscle Group I (trapezius, levator scapulae, serratus magnus) and II (pectoralis major II (costosternal), latissimus dorsi and teres major, pectoralis minor; rhomboid)?    <input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes, complete the Muscle Injuries questionnaire.</p>
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**SECTION VI - ROTATOR CUFF CONDITIONS**

<p>6A. Complete the following:</p> <p>Hawkins' Impingement Test: Forward flex the arm to 90 degrees with the elbow bent to 90 degrees. Internally rotate arm. Pain on internal rotation indicates a positive test; may signify rotator cuff tendinopathy or tear.</p> <p><input type="checkbox"/> Positive    <input type="checkbox"/> Negative    <input type="checkbox"/> Unable to test    <input type="checkbox"/> N/A</p> <p>Empty Can Test: Abduct arm to 90 degrees and forward flex 30 degrees. Patient turns thumbs down and resists downward force applied by the examiner. Weakness indicates a positive test; may indicate rotator cuff pathology, including supraspinatus tendinopathy or tear.</p> <p><input type="checkbox"/> Positive    <input type="checkbox"/> Negative    <input type="checkbox"/> Unable to test    <input type="checkbox"/> N/A</p> <p>External rotation/infraspinatus strength test: Patient holds arms at side with elbow flexed 90 degrees. Patient externally rotates against resistance. Weakness indicates a positive test; may be associated with infraspinatus tendinopathy or tear.</p> <p><input type="checkbox"/> Positive    <input type="checkbox"/> Negative    <input type="checkbox"/> Unable to test    <input type="checkbox"/> N/A</p> <p>Lift-off subscapularis test: Patient internally rotates arm behind lower back, pushes against examiner's hand. Weakness indicates a positive test; may indicate subscapularis tendinopathy or tear.</p> <p><input type="checkbox"/> Positive    <input type="checkbox"/> Negative    <input type="checkbox"/> Unable to test    <input type="checkbox"/> N/A</p> <p>6B. If unable to test, is a rotator cuff condition suspected? <input type="checkbox"/> Yes    <input type="checkbox"/> No If yes, please describe:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	<p>6A. Complete the following:</p> <p>Hawkins' Impingement Test: Forward flex the arm to 90 degrees with the elbow bent to 90 degrees. Internally rotate arm. Pain on internal rotation indicates a positive test; may signify rotator cuff tendinopathy or tear.</p> <p><input type="checkbox"/> Positive    <input type="checkbox"/> Negative    <input type="checkbox"/> Unable to test    <input type="checkbox"/> N/A</p> <p>Empty Can Test: Abduct arm to 90 degrees and forward flex 30 degrees. Patient turns thumbs down and resists downward force applied by the examiner. Weakness indicates a positive test; may indicate rotator cuff pathology, including supraspinatus tendinopathy or tear.</p> <p><input type="checkbox"/> Positive    <input type="checkbox"/> Negative    <input type="checkbox"/> Unable to test    <input type="checkbox"/> N/A</p> <p>External rotation/infraspinatus strength test: Patient holds arms at side with elbow flexed 90 degrees. Patient externally rotates against resistance. Weakness indicates a positive test; may be associated with infraspinatus tendinopathy or tear.</p> <p><input type="checkbox"/> Positive    <input type="checkbox"/> Negative    <input type="checkbox"/> Unable to test    <input type="checkbox"/> N/A</p> <p>Lift-off subscapularis test: Patient internally rotates arm behind lower back, pushes against examiner's hand. Weakness indicates a positive test; may indicate subscapularis tendinopathy or tear.</p> <p><input type="checkbox"/> Positive    <input type="checkbox"/> Negative    <input type="checkbox"/> Unable to test    <input type="checkbox"/> N/A</p> <p>6B. If unable to test, is a rotator cuff condition suspected? <input type="checkbox"/> Yes    <input type="checkbox"/> No If yes, please describe:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
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**SECTION VII - SHOULDER INSTABILITY, DISLOCATION OR LABRAL PATHOLOGY**

<p><b>Right shoulder</b></p> <p>7A. Complete the following:</p> <p>Crank Apprehension and Relocation Test: With patient supine, abduct patient's arm to 90 degrees and flex elbow 90 degrees. Pain and sense of instability with further external rotation may indicate shoulder instability.</p> <p><input type="checkbox"/> Positive    <input type="checkbox"/> Negative    <input type="checkbox"/> Unable to test    <input type="checkbox"/> N/A</p> <p>7B. If unable to test, is shoulder instability, dislocation or labral pathology suspected? <input type="checkbox"/> Yes    <input type="checkbox"/> No If yes, please describe</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	<p><b>Left shoulder</b></p> <p>7A. Complete the following:</p> <p>Crank Apprehension and Relocation Test: With patient supine, abduct patient's arm to 90 degrees and flex elbow 90 degrees. Pain and sense of instability with further external rotation may indicate shoulder instability.</p> <p><input type="checkbox"/> Positive    <input type="checkbox"/> Negative    <input type="checkbox"/> Unable to test    <input type="checkbox"/> N/A</p> <p>7B. If unable to test, is shoulder instability, dislocation or labral pathology suspected? <input type="checkbox"/> Yes    <input type="checkbox"/> No If yes, please describe:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
<p>7C. Is there shoulder instability, dislocation or labral pathology? <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p>7C. Is there shoulder instability, dislocation or labral pathology? <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
<p>7D. Does the Veteran have mechanical symptoms (clicking, catching, etc.)? <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p>7D. Does the Veteran have mechanical symptoms (clicking, catching, etc.)? <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
<p>7E. Are there current residuals of recurrent dislocation (subluxation) of the glenohumeral (scapulohumeral) joint? <input type="checkbox"/> Yes    <input type="checkbox"/> No If yes, check all that apply:</p> <p><input type="checkbox"/> Infrequent episodes and guarding of movement only at shoulder level (flexion and/or abduction at 90°)</p> <p><input type="checkbox"/> Frequent episodes and guarding of all arm movements</p> <p>Affects range of motion?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p>7E. Are there current residuals of recurrent dislocation (subluxation) of the glenohumeral (scapulohumeral) joint? <input type="checkbox"/> Yes    <input type="checkbox"/> No If yes, check all that apply:</p> <p><input type="checkbox"/> Infrequent episodes and guarding of movement only at shoulder level (flexion and/or abduction at 90°)</p> <p><input type="checkbox"/> Frequent episodes and guarding of all arm movements</p> <p>Affects range of motion?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>



**SECTION VIII - CLAVICLE, SCAPULA, ACROMIOCLAVICULAR (AC) JOINT AND STERNOCLAVICULAR JOINT CONDITIONS**

8A. Complete the following:

Cross-body adduction test: Passively adduct arm across the patient's body toward the contralateral shoulder. Pain may indicate acromioclavicular joint pathology.

Positive     Negative     Unable to test     N/A

8B. If unable to test, is a clavicle, scapula, acromioclavicular (AC) joint or sternoclavicular joint condition suspected?     Yes     No    If yes, please describe:

8A. Complete the following:

Cross-body adduction test: Passively adduct arm across the patient's body toward the contralateral shoulder. Pain may indicate acromioclavicular joint pathology.

Positive     Negative     Unable to test     N/A

8B. If unable to test, is a clavicle, scapula, acromioclavicular (AC) joint or sternoclavicular joint condition suspected?     Yes     No    If yes, please describe:

8C. Is there a clavicle, scapula, acromioclavicular (AC) joint, sternoclavicular joint condition or other impairment?     Yes     No    If yes, indicate severity:

Malunion of clavicle or scapula

Nonunion of clavicle or scapula without loose movement

Nonunion of clavicle or scapula with loose movement

Dislocation (acromioclavicular separation or sternoclavicular dislocation)

Other (describe):

8D. Does the clavicle or scapula condition affect range of motion of the shoulder (glenohumeral joint)?     Yes     No

8C. Is there a clavicle, scapula, acromioclavicular (AC) joint, sternoclavicular joint condition or other impairment?     Yes     No    If yes, indicate severity:

Malunion of clavicle or scapula

Nonunion of clavicle or scapula without loose movement

Nonunion of clavicle or scapula with loose movement

Dislocation (acromioclavicular separation or sternoclavicular dislocation)

Other (describe):

8D. Does the clavicle or scapula condition affect range of motion of the shoulder (glenohumeral joint)?     Yes     No

8E. Is there tenderness on palpation of the AC joint?     Yes     No

8E. Is there tenderness on palpation of the AC joint?     Yes     No

**SECTION IX - CONDITIONS OR IMPAIRMENTS OF THE HUMERUS**

9A. Does the Veteran have loss of head (flail shoulder), nonunion (false flail shoulder), or fibrous union of the humerus?     Yes     No    If yes, check all that apply:

Loss of head (flail shoulder)     Nonunion (false flail shoulder)     Fibrous union

9B. Does the Veteran have malunion of the humerus with moderate or marked deformity?:     Yes     No    If yes, indicate severity:

Moderate deformity     Marked deformity

9C. Does the humerus condition affect range of motion of the shoulder (glenohumeral joint)?     Yes     No

9A. Does the Veteran have loss of head (flail shoulder), nonunion (false flail shoulder), or fibrous union of the humerus?     Yes     No    If yes, check all that apply:

Loss of head (flail shoulder)     Nonunion (false flail shoulder)     Fibrous union

9B. Does the Veteran have malunion of the humerus with moderate or marked deformity?:     Yes     No    If yes, indicate severity:

Moderate deformity     Marked deformity

9C. Does the humerus condition affect range of motion of the shoulder (glenohumeral joint)?     Yes     No

**SECTION X - SURGICAL PROCEDURES**

10. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):

No surgery

Total shoulder joint replacement    Date of surgery: \_\_\_\_\_

Residuals:     None     Intermediate degrees of residual weakness, pain, or limitation of motion

Chronic residuals consisting of severe painful motion or weakness

Other residuals, describe: \_\_\_\_\_

Arthroscopic or other shoulder surgery

Date of Surgery: \_\_\_\_\_    Type of Surgery: \_\_\_\_\_

Describe residuals:

10. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):

No surgery

Total shoulder joint replacement    Date of surgery: \_\_\_\_\_

Residuals:     None     Intermediate degrees of residual weakness, pain, or limitation of motion

Chronic residuals consisting of severe painful motion or weakness

Other residuals, describe: \_\_\_\_\_

Arthroscopic or other shoulder surgery

Date of Surgery: \_\_\_\_\_    Type of Surgery: \_\_\_\_\_

Describe residuals:

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

11A. Does the Veteran have any other pertinent physical findings, complications, signs, or symptoms related to any conditions listed in the diagnosis section above?  
 Yes  No If yes, describe (brief summary):

11B. Does the Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis section?  
 Yes  No If yes, also complete the appropriate dermatological questionnaire.

11C. Comments, if any:

**SECTION XII - ASSISTIVE DEVICES**

12A. Does the Veteran use any assistive devices?  Yes  No

If yes, identify the assistive devices used. Check all that apply and indicate frequency:

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

12B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition:

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

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

13A. Due to the Veteran's shoulder or arm condition(s), is there functional impairment of an extremity such that no effective functions remain other than that which would be equally well-served by an amputation with prosthesis (functions of the upper extremity include grasping, manipulation, etc.)?

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

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

13B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function, and provide specific examples (brief summary):

**SECTION XIV - DIAGNOSTIC TESTING**

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

14A. Have imaging studies been performed in conjunction with this examination?  Yes  No

14B. If yes, is degenerative or post-traumatic arthritis documented?  Yes  No If yes, indicate side:  Right  Left  Both

14C. If yes, provide type of test or procedure, date and results (brief summary):

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

14D. 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):

14E. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed condition(s):

**SECTION XV - 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.

15A. 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 XVI - REMARKS**

16A. Remarks (if any – please identify the section to which the remark pertains when appropriate):

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

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

17A. Examiner's signature:

17B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

17C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

17D. Date Signed:

17E. Examiner's phone/fax numbers:

17F. National Provider Identifier (NPI) number:

17G. Medical license number and state:

17H. Examiner's address: