BACK (THORACOLUMBAR SPINE) CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

NAME OF CLAIMANT/VETERAN:	CLAIMANT/VETERAN'S SOCIAL SECURITY NUMBER:	DATE OF EXAMINATION: 12/13/2023

Note to examiner **-** The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

Is this questionnaire being completed in conjunction with VA 21-2507, C&P examination request?

☒ Yes ☐ No

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

☒ In-person examination

☒ Records reviewed

☐ Examination via approved video telehealth

☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

Indicate the method used to obtain medical information to complete this document:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

Evidence Reviewed (check all that apply):

☐ Not requested ☐ No records were reviewed

☐ VA claims file (hard copy paper C-file)

☒ VA e-folder

☐ VA electronic health record

☐ Other, please identify other evidence reviewed:

Evidence Comments:

SECTION I - DIAGNOSIS

Note**:** These are condition(s) for which an evaluation has been requested on an exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. List the claimed condition(s) that pertain to this questionnaire:

lumbar spine condition

Note: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in the remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis or an approximate date determined through record review or reported history.

1B. Select diagnoses associate 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)

	ICD Code:	Date of diagnosis:
☐ Ankylosing spondylitis		
☐ Degenerative arthritis		
☐ Degenerative disc disease other than intervertebral disc syndrome (IVDS)		

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☒ Lumbosacral strain	S33.8XXA	12/2023
☐ Intervertebral disc syndrome (Note: See VA definition of IVDS in Section XI.)		
☐ Sacroiliac injury		
☐ Sacroiliac weakness		
☐ Segmental instability		
☐ Spinal fusion		
☐ Spinal stenosis		
☐ Spondylolisthesis		
☐ Traumatic paralysis, complete		
☐ Vertebral dislocation		
☐ Vertebral fracture		
☐ Other (specify):		
Other diagnosis #1:		
Other diagnosis #2:		
Other diagnosis #3:		

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

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's thoracolumbar spine condition (brief summary):

Onset Date:
~ 1999

Details of Onset:
Veteran states he was involved in a couple MVA during service, but notes prior to accidents he as involved in the navy honor guard where he had to stand at attention for hours at a time.

Course since Onset:
Veteran states his back pain has worsened over the years. Describes the back pain as constant dull ache 6/10 with intermittent sharp pain 10/10. Aggravating factors includes twisting, bending, sitting >60min.

Current Symptoms:
Describes the back pain as constant dull ache 6/10 with intermittent sharp pain 10/10. Aggravating factors includes twisting, bending, sitting >60min.

Current Treatment/Frequency:
naproxen, ibuprofen prn. no formal therapy currently. States previously was seen by chiropractor, but not currently.

2B. Does the Veteran report flare-ups of the thoracolumbar spine?

☐ Yes ☒ No

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

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:

Describes the back pain as constant dull ache 6/10 with intermittent sharp pain 10/10. Aggravating factors includes twisting, bending, sitting >60min.

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

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factors to be considered. Subsequent questions take into account additional factors such as pain, fatigue, weakness, lack of endurance, or incoordination. If there is pain noted on examination, it is important to understand whether or not that pain itself contributes to functional loss. Ideally, a claimant would be seen immediately after repetitive use over time or during a flare-up; however, this is not always feasible.

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

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

3A. Initial ROM measurements

☐ All Normal

☒ Abnormal or outside of normal range

☐ Unable to test

☐ Not indicated

If “Unable to test” or “Not indicated”, please explain:

If ROM is outside of “normal” range, but is normal for the Veteran (for reasons other than a back condition, such as age, body habitus, neurologic disease), please describe:

If abnormal, does the range of motion itself contribute to a functional loss?

☒ Yes ☐ No

If yes, please explain:

Describes the back pain as constant dull ache 6/10 with intermittent sharp pain 10/10. Aggravating factors includes twisting, bending, sitting >60min.

Note**:** For any joint condition, examiners should address pain on both passive and active motion, and on both weight-bearing and nonweight-bearing. If testing cannot be performed or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation must be given below. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).

Can testing be performed?

☐ Yes ☐ No

If no, provide an explanation:

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

Forward flexion endpoint (90 degrees):	50	degrees
Extension endpoint (30 degrees):	5	degrees
Right lateral flexion endpoint (30 degrees):	20	degrees
Left lateral flexion endpoint (30 degrees):	20	degrees
Right lateral rotation endpoint (30 degrees):	20	degrees
Left lateral rotation endpoint (30 degrees):	25	degrees

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

☒ Forward flexion

☒ Extension

☒ Right lateral flexion

☒ Left lateral flexion

☒ Right lateral rotation

☒ Left lateral rotation

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

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Forward flexion: degree endpoint (if different than above)

Extension: degree endpoint (if different than above)

Right lateral flexion: degree endpoint (if different than above)

Left lateral flexion: degree endpoint (if different than above)

Right lateral rotation: degree endpoint (if different than above)

Left lateral rotation: degree endpoint (if different than above)

Passive Range of Motion – Perform passive range of motion and provide the ROM values.

Was passive range of motion testing performed?

☐ Yes ☒ No

If not, indicate why passive range of motion testing was not performed:

☒ Medically contraindicated (e.g., it may cause the Veteran severe pain or the risk of further injury). It is not medically advisable to conduct passive range of motion testing because (provide explanation).

☐ Testing not necessary because (provide explanation).

☐ Other (provide explanation).

Explanation:

Passive ROM not performed due to potential to cause pain to veteran.

Forward flexion endpoint (90 degrees):	degrees	☐	Same as active ROM
Extension endpoint (30 degrees):	degrees	☐	Same as active ROM
Right lateral flexion endpoint (30 degrees):	degrees	☐	Same as active ROM
Left lateral flexion endpoint (30 degrees):	degrees	☐	Same as active ROM
Right lateral rotation endpoint (30 degrees):	degrees	☐	Same as active ROM
Left lateral rotation endpoint (30 degrees):	degrees	☐	Same as active ROM

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

☐ Forward flexion

☐ Extension

☐ Right lateral flexion

☐ Left lateral flexion

☐ Right lateral rotation

☐ Left lateral rotation

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

Forward flexion: Degree endpoint (if different than above)

Extension: Degree endpoint (if different than above)

Right lateral flexion: Degree endpoint (if different than above)

Left lateral flexion: Degree endpoint (if different than above)

Right lateral rotation: Degree endpoint (if different than above)

Left lateral 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

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☐ Passive motion

☐ On rest/non-movement

☒ Causes functional loss (if checked describe in the comments box below)

☐ Does not result in/cause functional loss

Comments:

Describes the back pain as constant dull ache 6/10 with intermittent sharp pain 10/10. Aggravating factors includes twisting, bending, sitting >60min.

Is there objective evidence of crepitus?

☐ Yes ☒ No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?

☒ Yes ☐ No

If yes, describe location, severity, and relationship to condition(s):

tenderness to palpation

Location:
midline lumbar spine and bilateral paraspinous muscles

Severity:
moderate

Relationship to claimed condition:
Directly related to claimed condition

3B. Observed repetitive use ROM

Is the Veteran able to perform repetitive use testing with at least three repetitions?

☒ Yes ☐ No

If no, please explain:

Is there additional loss of function or range of motion after three repetitions?

☐ Yes ☒ No

If yes, please respond to the following after completion of the three repetitions:

Forward flexion endpoint (90 degrees):	degrees
Extension endpoint (30 degrees):	degrees
Right lateral flexion endpoint (30 degrees):	degrees
Left lateral flexion endpoint (30 degrees):	degrees
Right lateral rotation endpoint (30 degrees):	degrees
Left lateral rotation endpoint (30 degrees):	degrees

Select all factors that cause this functional loss: (check all that apply)

☒ N/A

☐ Pain

☐ Fatigability

☐ Weakness

☐ Lack of endurance

☐ Incoordination

☐ Other:

Note: When pain is associated with movement, the examiner must give a statement on whether pain could significantly limit functional ability during flare-ups and/or after repeated use over time in terms of additional loss of range of motion. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare-ups - even if not directly observed during a flare-up and/or after repeated use over time.

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3C. Repeated use over time

Is the Veteran being examined immediately after repeated use over time?

☐ Yes ☒ No

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time?

☒ Yes ☐ No

Select all factors that cause this functional loss: (check all that apply)

☐ N/A

☒ Pain

☐ Fatigability

☐ Weakness

☐ Lack of endurance

☐ Incoordination

☐ Other:

Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran:

Forward flexion endpoint (90 degrees):	50	degrees
Extension endpoint (30 degrees):	5	degrees
Right lateral flexion endpoint (30 degrees):	20	degrees
Left lateral flexion endpoint (30 degrees):	20	degrees
Right lateral rotation endpoint (30 degrees):	20	degrees
Left lateral rotation endpoint (30 degrees):	25	degrees

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence):

3D. Flare-ups

Is the Veteran being examined during a flare-up?

☐ Yes ☒ No

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare-ups?

☐ Yes ☒ No

Select all factors that cause this functional loss: (check all that apply)

☒ N/A

☐ Pain

☐ Fatigability

☐ Weakness

☐ Lack of endurance

☐ Incoordination

☐ Other:

Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran:

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Forward flexion endpoint (90 degrees): degrees

Extension endpoint (30 degrees): degrees

Right lateral flexion endpoint (30 degrees): degrees

Left lateral flexion endpoint (30 degrees): degrees

Right lateral rotation endpoint (30 degrees): degrees

Left lateral rotation endpoint (30 degrees): degrees

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence):

The Veteran denies flare ups

3E. Guarding and muscle spasm

Does the Veteran have localized tenderness, guarding or muscle spasm of the thoracolumbar spine?

☒ Yes ☐ No

Localized tenderness:

☐ None
☒ Not resulting in abnormal gait or abnormal spinal contour

Provide description and/or etiology:

tenderness to palpation of midline lumbar spine and bilateral paraspinous muscles

Muscle spasm:

☒ None
☐ Resulting in abnormal gait or abnormal spinal contour
☐ Not resulting in abnormal gait or abnormal spinal contour
☐ Unable to evaluate, describe below:

Provide description and/or etiology:

Guarding:

☐ None
☒ Resulting in abnormal gait or abnormal spinal contour
☐ Not resulting in abnormal gait or abnormal spinal contour
☐ Unable to evaluate, describe below:

Provide description and/or etiology:

antalgic gait from back pain

3F. Additional factors contributing to disability

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:

☐ None

☒ Interference with sitting

☐ Interference with standing

☐ Swelling

☐ Deformity

☐ Disturbance of locomotion

☒ Less movement than normal

☐ More movement than normal

☐ Weakened movement

☐ Atrophy of disuse

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☐ Instability of station

☐ Other, describe:

Please describe additional contributing factors of disability:

Less movement than normal:
decreased ROM

Interference with Sitting:
Aggravating factors includes twisting, bending, sitting >60min.

SECTION IV - MUSCLE STRENGTH TESTING

4A. Muscle strength – rate strength according to the following scale:

0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance
5/5 Normal strength

Side	Flexion/ Extension	Rate/ Strength	Side	Flexion/ Extension	Rate/ Strength
RIGHT	Hip Flexion	5/5	LEFT	Hip Flexion	5/5
	Knee Extension	5/5		Knee Extension	5/5
	Ankle Plantar Flexion	5/5		Ankle Plantar Flexion	5/5
	Ankle Dorsiflexion	5/5		Ankle Dorsiflexion	5/5
	Great Toe Extension	5/5		Great Toe Extension	5/5

4B. Does the Veteran have muscle atrophy?

☐ Yes ☒ No

4C. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section?

☐ Yes ☐ No

If no, provide rationale:

4D. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.

Provide measurements in centimeters of normal side and atrophied side, measured at maximum muscle bulk.

Circumference of normal side: cm Circumference of atrophied side: cm

SECTION V - REFLEX EXAM

5A. Rate deep tendon reflexes (DTRs) according to the following scale:

0 Absent
1+ Hypoactive
2+ Normal
3+ Hyperactive without clonus
4+ Hyperactive with clonus

RIGHT: Knee: 2+ Ankle: 2+

LEFT: Knee: 2+ Ankle: 2+

SECTION VI - SENSORY EXAM

6A. Provide results for sensation to light touch (dermatome) testing:

Side	Upper Anterior Thigh (L2)	Thigh/Knee (L3/4)	Lower Leg/Ankle (L4/L5/S1)	Foot/Toes (L5)
Right	☐ Normal ☒ Decreased	☐ Normal ☒ Decreased	☐ Normal ☒ Decreased	☐ Normal ☒ Decreased

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	☐ Absent	☐ Absent	☐ Absent	☐ Absent
Left	☒ Normal ☐ Decreased ☐ Absent	☒ Normal ☐ Decreased ☐ Absent	☒ Normal ☐ Decreased ☐ Absent	☒ Normal ☐ Decreased ☐ Absent

Other sensory findings, if any:

SECTION VII - STRAIGHT LEG RAISING TEST

Note**:** This test can be performed with the Veteran seated or supine. Raise each straightened leg until pain begins, typically at 30-70 degrees of elevation. The test is positive if the pain radiates below the knee, not merely limited to the back or hamstring muscles. Pain is often increased on dorsiflexion of the foot, and relieved by knee flexion. A positive test suggests radiculopathy, often due to disc herniation.

7A. Provide straight leg raising test results:

Right: ☒ Negative ☐ Positive ☐ Unable to perform

Left: ☒ Negative ☐ Positive ☐ Unable to perform

If "Unable to perform," please explain:

SECTION VIII - RADICULOPATHY

Note**:** For purposes of this examination, the diagnoses of IVDS and radiculopathy can be made by a history of characteristic radiating pain and/or sensory changes in the legs, and objective clinical findings, which may include the asymmetrical loss or decrease of reflexes, decreased strength and/or abnormal sensation. Electromyography (EMG) studies are rarely required to diagnose radiculopathy in the appropriate clinical setting.

Does the Veteran have radicular pain or any other signs or symptoms due to radiculopathy?

☐ Yes ☒ No

If yes, complete sections 8A - 8D.

8A. Indicate symptoms' location and severity (check all that apply):

Note: For VA purposes, when the involvement is wholly sensory, the evaluation should be for the mild, or at the most, the moderate degree.

Constant pain (may be excruciating at times):	Right lower extremity:	☐ None ☐ Mild ☐ Moderate ☐ Severe
	Left lower extremity:	☐ None ☐ Mild ☐ Moderate ☐ Severe
Intermittent pain (usually dull):	Right lower extremity:	☐ None ☐ Mild ☐ Moderate ☐ Severe
	Left lower extremity:	☐ None ☐ Mild ☐ Moderate ☐ Severe
Paresthesias and/or dysesthesias:	Right lower extremity:	☐ None ☐ Mild ☐ Moderate ☐ Severe
	Left lower extremity:	☐ None ☐ Mild ☐ Moderate ☐ Severe
Numbness:	Right lower extremity:	☐ None ☐ Mild ☐ Moderate ☐ Severe
	Left lower extremity:	☐ None ☐ Mild ☐ Moderate ☐ Severe

8B. Does the Veteran have any other signs or symptoms of radiculopathy?

☐ Yes ☐ No

If yes, describe:

8C. Indicate nerve roots involved (check all that apply):

☐ Involvement of L2/L3/L4 nerve roots (femoral nerve)

If checked, indicate side affected:

☐ Right ☐ Left ☐ Both

☐ Involvement of L4/L5/S1/S2/S3 nerve roots (sciatic nerve)

If checked, indicate side affected:

☐ Right ☐ Left ☐ Both

☐ Other nerves (specify nerve and side(s) affected):

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If checked, indicate side affected:

☐ Right ☐ Left ☐ Both

8D. For any abnormal or positive identified neurological findings identified in Sections 4-8, explain the likely cause of those identified symptoms:

Section 6: Right Sensory Exam:
unknown, subjective. Decreased sensation along lateral aspect of thigh and lower leg.

SECTION IX - ANKYLOSIS

Note: For VA compensation purposes, unfavorable ankylosis is a condition in which the entire cervical spine, the entire thoracolumbar spine, or the entire spine is fixed in flexion or extension, and the ankylosis results in one or more of the following: difficulty walking because of a limited line of vision; restricted opening of the mouth and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms due to pressure of the costal margin on the abdomen; dyspnea or dysphagia; atlantoaxial or cervical subluxation or dislocation; or neurologic symptoms due to nerve root stretching. Fixation of a spinal segment in neutral position (zero degrees) always represents favorable ankylosis.

9A. Is there ankylosis of the spine?

☐ Yes ☒ No

If yes, indicate severity of ankylosis:

☐ Unfavorable ankylosis of the entire spine

☐ Unfavorable ankylosis of the entire thoracolumbar spine

☐ Favorable ankylosis of the entire thoracolumbar spine

9B. Comments, if any:

SECTION X - OTHER NEUROLOGIC ABNORMALITIES

10A. Does the Veteran have any other neurologic abnormalities or findings (other than those identified in Sections 4 – 8) related to a thoracolumbar spine condition (such as bowel or bladder problems/pathologic reflexes)?

☐ Yes ☒ No

If yes, describe condition and how it is related:

Note**:** If there are neurological abnormalities other than radiculopathy, also complete appropriate questionnaire for each condition identified.

SECTION XI - INTERVERTEBRAL DISC SYNDROME (IVDS) AND EPISODES REQUIRING BED REST

Note**:** IVDS is a group of signs and symptoms due to disc herniation with compression and/or irritation of the adjacent nerve root that commonly includes back pain and sciatica (pain along the course of the sciatic nerve) in the case of lumbar disc disease, and neck and arm or hand pain in the case of cervical disc disease. Imaging studies are not required to make the diagnosis of IVDS.

11A. Does the Veteran have IVDS of the thoracolumbar spine?

☐ Yes ☒ No

11B. If yes to question 11A above, has the Veteran had any episodes of acute signs and symptoms due to IVDS that required bed rest prescribed by a physician and treatment by a physician in the past 12 months?

☐ Yes ☐ No

If yes, select the total duration over the past 12 months:

☐ With no episodes of bed rest during the past 12 months

☐ With episodes of bed rest having a total duration of at least 1 week but less than 2 weeks during the past 12 months

☐ With episodes of bed rest having a total duration of at least 2 weeks but less than 4 weeks during the past 12 months

☐ With episodes of bed rest having a total duration of at least 4 weeks but less than 6 weeks during the past 12 months

☐ With episodes of bed rest having a total duration of at least 6 weeks during the past 12 months

11C. If yes to question 11B above, provide the following documentation that supports the yes response:

☐ Medical history as described by the Veteran only, without documentation:

☐ Medical history as shown and documented in the Veteran's file:

Individual date(s) of each treatment record(s) reviewed:

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Facility/provider:

Describe treatment:

☐ Other, describe:

SECTION XII - ASSISTIVE DEVICES

12A. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible?

☒ Yes ☐ No

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

☐ Wheelchair	Frequency of use:	☐ Occasional ☐ Regular ☐ Constant
☒ Brace	Frequency of use:	☒ Occasional ☐ Regular ☐ Constant
☐ Crutches	Frequency of use:	☐ Occasional ☐ Regular ☐ Constant
☐ Cane	Frequency of use:	☐ Occasional ☐ Regular ☐ Constant
☐ Walker	Frequency of use:	☐ Occasional ☐ Regular ☐ Constant
☐ Other:	Frequency of use:	☐ Occasional ☐ Regular ☐ Constant

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

Brace: lumbosacral strain
Side device used on: Both
Side of condition requiring device: Both

SECTION XIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

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

13A. Due to the Veteran's thoracolumbar spine condition, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)

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

If yes, indicate extremities for which this applies:

☐Right lower ☐Left lower ☐Right upper ☐Left upper

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

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

14A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the diagnosis section above?

☐ Yes ☒ No

If yes, describe (brief summary):

14B. Does the Veteran have any scars or other disfigurement of the skin related to any conditions or to the treatment of any conditions listed in the diagnosis section?

☐ Yes ☒ No

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If yes, complete appropriate dermatological questionnaire.

14C. Comments, if any:

SECTION XV - DIAGNOSTIC TESTING

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

Imaging studies are not required to make the diagnosis of IVDS. Electromyography (EMG) studies are rarely required to diagnose radiculopathy in the appropriate clinical setting.

15A. Have imaging studies been performed in conjunction with this examination?

☐ Yes ☒ No

15B. If yes, is degenerative or post-traumatic arthritis documented?

☐ Yes ☐ No

15C. If yes, provide type of test or procedure, date and results (brief summary):

15D. Does the Veteran have imaging evidence of a thoracolumbar vertebral fracture?

☐ Yes ☒ No

If yes, is there loss of 50 percent or more of height?

☐ Yes ☐ No

15E. Are there any other significant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

☐ Yes ☒ No

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

15F. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

SECTION XVI - 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.

16A. 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:

Current OR if retired/unemployed, previous occupation
defense contractor

2-4 weeks work time lost in last 12 months

Veteran admits to missing a 1-2 days per month due to back pain. Describes the back pain as constant dull ache 6/10 with intermittent sharp pain 10/10. Aggravating factors includes twisting, bending, sitting >60min.

SECTION XVII - REMARKS

17A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

Is there a need for the Veteran/Service Member to follow up with his or her primary care provider regarding any life threatening or abnormal findings in this examination (not limited to claimed condition(s))? Yes

If yes, was the Veteran/Service Member notified to follow up with his or her primary care provider? Yes

Reason to follow up with PCP:
Veteran was encouraged to follow up with PCP for further evaluation and treatment.

Was a copy of the test results identifying the life threatening or abnormal findings provided to the Veteran or the Veteran's primary care provider? Yes

Section III: A goniometer was used to measure ROM.

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Reason X-rays were not needed or not performed:
X-rays on the day of exam were not clinically indicated

For claim of lumbar spine condition, diagnosis of lumbosacral strain rendered due to decreased ROM on exam.

Is the Veteran homeless? No

Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION XVIII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

18A. EXAMINER'S SIGNATURE:	18B. EXAMINER'S PRINTED NAME:	18C. DATE SIGNED:
PA-C	Christine Ward Physician Assistant – General Practice	12/13/2023
18D. EXAMINER'S PHONE NUMBER:	18E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER:	18F. MEDICAL LICENSE AND STATE NUMBER:
910-238-4443 910-333-0203	1730111824	0010-09863, NC

18G. EXAMINER'S ADDRESS:

34 Office Park Drive Suite 200 Jacksonville NC 28546

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MEDICAL OPINION
DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT – THE DEPARTMENT OF VETERAN'S AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN:	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER:	EXAMINATION DATE:
Anthony Robert	*xxxxx*	12/13/2023

Note to examiner **-** The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

Is this questionnaire being completed in conjunction with VA 21-2507, C&P examination request?

☒ Yes ☐ No

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

☒ In-person examination

☒ Records reviewed

☐ Examination via approved video telehealth

☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

Indicate the method used to obtain medical information to complete this document:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

Evidence Reviewed (check all that apply):

☐ No records were reviewed

☐ Not requested

☐ VA claims file (hard copy paper C-file)

☒ VA e-folder

☐ VA electronic health record

☐ Other, please identify other evidence reviewed:

Evidence Comments:

Pg 144: entrance exam 6/1998. No medical conditions noted. BP 126/75
Pg 151: separation exam ?4/2002 reviewed. No medical conditions noted. BP 127/79
Pg 153: separation DD2807 4/2002 reviewed. Silent for back pain, positive for knee trouble, positive for hay fever/sinusitis, positive for asthma. Notes patellofemoral syndrome for knee condition.
Pg 111: PCP note 2/2000 s/p MVA. Diagnosed with paraspinal strain secondary to MVA. Notes cervical and thoracic muscle spasms. No lumbar symptoms noted.
Pg 128: PCP note 5/1999 s/p MVA. Diagnosed with lower lumbar strain secondary to low speed MVA. R knee contusion.
Pg 812: preventive medicine note 2/2022 notes neck and back pain. No diagnosis rendered.

SECTION I - DEFINITIONS

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

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

SECTION II - RESTATEMENT OF REQUESTED OPINION

2a. Insert requested opinion from general remarks:
Does the Veteran have a diagnosis of Lumbar spine condition that is at least as likely as not (likelihood is at least approximately balanced or nearly

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equal, if not higher) incurred in or caused by (the) lumbar spine condition during service?

2b. Indicate type of exam for which opinion has been requested *(e.g. Skin Diseases)*:
DBQ MUSC Back (Thoracolumbar Spine)

SECTION III – MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

Choose the statement that most closely approximates the etiology of this claimed condition.

☐ 3a. The claimed condition was at least as likely as not *(likelihood is at least approximately balanced or nearly equal, if not higher)* incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section C.

☒ 3b. The claimed condition was less likely than not *(likelihood is less than approximately balanced or nearly equal)* incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section C.

3c. Rationale:
Veteran has claimed lumbar spine condition as being directly related to military service. Based on review of the available evidence, it is less likely than not that the claimed condition is due to service as there is a lack of substantiating evidence supporting a nexus between the current diagnosis of lumbosacral strain and military service. Without chronicity during service or after service, a post-service event, illness, or injury is considered to be a more likely etiology.

The veteran was diagnosed with lumbar strains secondary to MVA in both 1999 and 2000 during service, however separation exam and DD2807 in 2002 were silent for a back condition and thus felt the strains were acute and resolved at that time. A nexus has not been established.

SECTION IV – MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

☐ 4a. The claimed condition is at least as likely as not *(likelihood is at least approximately balanced or nearly equal, if not higher)* proximately due to or the result of the Veteran's service connected condition. Provide rationale in section C.

☐ 4b. The claimed condition is less likely than not *(likelihood is less than approximately balanced or nearly equal)* proximately due to or the result of Veteran's service connected condition. Provide rationale in section C.

4c. Rationale:

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

☐ 5a. The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section C.

☐ 5b. The claimed condition, which clearly and unmistakably existed prior to service, was clearly and unmistakably not aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section C.

5c. Rationale:

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

6a. Can you determine a baseline level of severity of *(claimed condition/diagnosis)* based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by *(service connected condition)*?

☐ Yes ☐ No

If "YES" to question 6a, answer the following:

i. Describe the baseline level of severity of *(claimed condition/diagnosis)* based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by *(service connected condition)*:

ii. Provide the date and nature of the medical evidence used to provide the baseline:

iii. Is The current severity of the *(claimed condition/diagnosis)* greater than the baseline?

☐ Yes ☐ No

If YES, was the Veteran's *(claimed condition/diagnosis)* at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?

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☐ Yes ☐ No *(provide rationale in section 6B.)*

If "NO" to question 6a, answer the following:

i. Provide rationale as to why a baseline cannot be established *(e.g. medical evidence is not sufficient to support a determination of a baseline level of severity)*:

ii. Regardless of an established baseline, was the Veteran's *(claimed condition/diagnosis)* at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?

☐ Yes ☐ No *(provide rationale in section 6B.)*

6b. Provide rationale:

SECTION VII - MEDICAL OPINION FOR TOXIC EXPOSURE RISK ACTIVITIES

Choose the statement that most closely approximates the etiology of this claimed condition.

☐ 7a. The claimed condition was at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) caused by the indicated toxic exposure risk activity(ies), after considering the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran. Provide rationale in section C.

☐ 7b. The claimed condition was less likely than not (likelihood is less than approximately balanced or nearly equal) caused by the indicated toxic exposure risk activity(ies), after considering the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran. Provide rationale in section C.

7c. Provide rationale:

SECTION VIII - OPINION REGARDING CONFLICTING MEDICAL EVIDENCE

8. I have reviewed the conflicting medical evidence and am providing the following opinion:

Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION IX – PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9a. PHYSICIAN'S SIGNATURE	9b. PHYSICIAN'S PRINTED NAME	9c. DATE SIGNED
PA-C	Christine Ward Physician Assistant – General Practice	12/13/2023

9d. PHYSICIAN'S PHONE/FAX NUMBERS	9e. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	9f. PHYSICIAN'S ADDRESS
910-238-4443 910-333-0203	1730111824 Lic. #: 0010-09863, NC	34 Office Park Drive Suite 200 Jacksonville NC 28546

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MEDICAL OPINION
DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT – THE DEPARTMENT OF VETERAN'S AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN:	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER:	EXAMINATION DATE:
Anthony Robert	*xxxxx*	12/13/2023

Note to examiner **-** The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

Is this questionnaire being completed in conjunction with VA 21-2507, C&P examination request?

☒ Yes ☐ No

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

☒ In-person examination

☒ Records reviewed

☐ Examination via approved video telehealth

☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

Indicate the method used to obtain medical information to complete this document:

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☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

Evidence Reviewed (check all that apply):

☐ No records were reviewed

☐ Not requested

☐ VA claims file (hard copy paper C-file)

☒ VA e-folder

☐ VA electronic health record

☐ Other, please identify other evidence reviewed:

Evidence Comments:

Pg 144: entrance exam 6/1998. No medical conditions noted. BP 126/75
Pg 151: separation exam ?4/2002 reviewed. No medical conditions noted. BP 127/79
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SECTION II - RESTATEMENT OF REQUESTED OPINION

2a. Insert requested opinion from general remarks:
Is the Veteran's Bilateral hips at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or the

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result of: Lumbar spine condition?

2b. Indicate type of exam for which opinion has been requested *(e.g. Skin Diseases)*:
DBQ MUSC Hip & Thigh

SECTION III – MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

Choose the statement that most closely approximates the etiology of this claimed condition.

☐ 3a. The claimed condition was at least as likely as not *(likelihood is at least approximately balanced or nearly equal, if not higher)* incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section C.

☐ 3b. The claimed condition was less likely than not *(likelihood is less than approximately balanced or nearly equal)* incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section C.

3c. Rationale:

SECTION IV – MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

☐ 4a. The claimed condition is at least as likely as not *(likelihood is at least approximately balanced or nearly equal, if not higher)* proximately due to or the result of the Veteran's service connected condition. Provide rationale in section C.

☒ 4b. The claimed condition is less likely than not *(likelihood is less than approximately balanced or nearly equal)* proximately due to or the result of Veteran's service connected condition. Provide rationale in section C.

4c. Rationale:
Claimed Secondary Condition:
bilateral hips
Service-connected Condition:
claimed lumbar spine condition
The conditions of bilateral hips and claimed lumbar spine condition are not medically related. The bilateral hips is a separate entity entirely from the claimed lumbar spine condition and unrelated to it. A thorough review of medical literature failed to demonstrate a causal relationship. A nexus has not been established.

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

☐ 5a. The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section C.

☐ 5b. The claimed condition, which clearly and unmistakably existed prior to service, was clearly and unmistakably not aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section C.

5c. Rationale:

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

6a. Can you determine a baseline level of severity of *(claimed condition/diagnosis)* based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by *(service connected condition)*?

☐ Yes ☐ No

If "YES" to question 6a, answer the following:

i. Describe the baseline level of severity of *(claimed condition/diagnosis)* based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by *(service connected condition)*:

ii. Provide the date and nature of the medical evidence used to provide the baseline:

iii. Is The current severity of the *(claimed condition/diagnosis)* greater than the baseline?

☐ Yes ☐ No

If YES, was the Veteran's *(claimed condition/diagnosis)* at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?

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☐ Yes ☐ No *(provide rationale in section 6B.)*

If "NO" to question 6a, answer the following:

i. Provide rationale as to why a baseline cannot be established *(e.g. medical evidence is not sufficient to support a determination of a baseline level of severity)*:

ii. Regardless of an established baseline, was the Veteran's *(claimed condition/diagnosis)* at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?

☐ Yes ☐ No *(provide rationale in section 6B.)*

6b. Provide rationale:

SECTION VII - MEDICAL OPINION FOR TOXIC EXPOSURE RISK ACTIVITIES

Choose the statement that most closely approximates the etiology of this claimed condition.

☐ 7a. The claimed condition was at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) caused by the indicated toxic exposure risk activity(ies), after considering the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran. Provide rationale in section C.

☐ 7b. The claimed condition was less likely than not (likelihood is less than approximately balanced or nearly equal) caused by the indicated toxic exposure risk activity(ies), after considering the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran. Provide rationale in section C.

7c. Provide rationale:

SECTION VIII - OPINION REGARDING CONFLICTING MEDICAL EVIDENCE

8. I have reviewed the conflicting medical evidence and am providing the following opinion:

Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION IX – PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9a. PHYSICIAN'S SIGNATURE	9b. PHYSICIAN'S PRINTED NAME	9c. DATE SIGNED
PA-C	Christine Ward Physician Assistant – General Practice	12/13/2023

9d. PHYSICIAN'S PHONE/FAX NUMBERS	9e. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	9f. PHYSICIAN'S ADDRESS
910-238-4443 910-333-0203	1730111824 Lic. #: 0010-09863, NC	34 Office Park Drive Suite 200 Jacksonville NC 28546

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HIP AND THIGH CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

NAME OF CLAIMANT/VETERAN:	CLAIMANT/VETERAN'S SOCIAL SECURITY NUMBER:	DATE OF EXAMINATION:
Anthony Robert	*xxxxx*	12/13/2023

NOTE TO EXAMINER: The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA21-2507, C&P EXAMINATION REQUEST? ☒ YES ☐ NO

HOW WAS THE EXAMINATION COMPLETED (CHECK ALL THAT APPLY)?

- ☒ In-person examination
- ☒ Records reviewed
- ☐ Examination via approved video telehealth
- ☐ Other, please specify in comments box

COMMENTS:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

- ☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.
- ☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

Evidence Reviewed (check all that apply):

- ☐ Not requested
- ☐ No records were reviewed
- ☐ VA claims file (hard copy paper C-file)
- ☒ VA e-folder
- ☐ VA electronic health record
- ☐ Other (please identify other evidence reviewed):

EVIDENCE COMMENTS:

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SECTION I - DIAGNOSIS

NOTE: These are condition(s) for which an evaluation has been requested or the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. LIST THE CLAIMED CONDITION(S) THAT PERTAIN TO THIS QUESTIONNAIRE:

bilateral hips

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 remarks section).*

	Side affected:			ICD Code:	Date of Diagnosis:	
	Right	Left	Both		Right	Left
☐ Osteoarthritis, hip	☐	☐	☐			
☐ Hip joint replacement	☐	☐	☐			
☐ Hip joint resurfacing	☐	☐	☐			
☐ Trochanteric pain syndrome (includes trochanteric bursitis)	☐	☐	☐			
☐ Femoral acetabular impingement syndrome (includes labral tears)	☐	☐	☐			
☐ Iliopsoas tendinitis	☐	☐	☐			
☐ Femoral neck stress fracture	☐	☐	☐			
☐ Avascular necrosis, hip	☐	☐	☐			
☐ Ankylosis of hip joint	☐	☐	☐			
☐ Degenerative arthritis, other than post-traumatic	☐	☐	☐			
☐ Arthritis, gonorrheal	☐	☐	☐			
☐ Arthritis, pneumococcic	☐	☐	☐			
☐ Arthritis, streptococcic	☐	☐	☐			
☐ Arthritis, syphilitic	☐	☐	☐			
☐ Arthritis, rheumatoid (multi-joints)	☐	☐	☐			
☐ Post-traumatic arthritis	☐	☐	☐			
☐ Arthritis, typhoid	☐	☐	☐			
☐ Other specified forms of athropathy (excluding gout) (specify)	☐	☐	☐			
☐ Osteoporosis, residuals of	☐	☐	☐			
☐ Osteomalacia, residuals of	☐	☐	☐			
☐ Bones, neplasm, benign	☐	☐	☐			
☐ Osteitis deformans	☐	☐	☐			
☐ Gout	☐	☐	☐			
☐ Bursitis	☐	☐	☐			
☐ Myositis	☐	☐	☐			
☐ Heterotopic ossification	☐	☐	☐			
☐ Tendinopathy (select one if known)						
☐ Tendinitis	☐	☐	☐			
☐ Tendinosis	☐	☐	☐			
☐ Tenosynovitis	☐	☐	☐			
☐ Inflammatory, other types (specify)	☐	☐	☐			

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	Side affected: Right	Left	Both	ICD Code:	Date of Diagnosis: Right	Left
☒ Other *(specify)*						
Other diagnosis #1: Hip strain	☐	☐	☒	S73.119A	12/2023	12/2023
Other diagnosis #2:	☐	☐	☐			
Other diagnosis #3:	☐	☐	☐			

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

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S HIP OR THIGH CONDITION *(brief summary)*:

Date of onset:
~ 1999

Details of onset:
Veteran states his hip pain worsened after the MVAs during service. Further notes prior to accidents he as involved in the navy honor guard where he had to stand at attention for hours at a time, which also caused bilateral hip pain.

Course since onset:
Veteran states his hip pain has worsened over the years. Describes the hip pain as a dull achy pain 4/10 with upwards of 7/10 when aggravated. Aggravating factors includes walking.

Current Symptoms:
Describes the hip pain as a dull achy pain 4/10 with upwards of 7/10 when aggravated. Aggravating factors includes walking.

Current Treatment and Frequency:
naproxen, ibuprofen prn. Stretching occasionally, no formal therapy.

2B. DOES THE VETERAN REPORT FLARE-UPS OF THE HIP OR THIGH?

☐ YES ☒ NO

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

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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?

[X] YES [ ] NO If "YES," document the Veteran's description of functional loss or functional impairment in his or her own words:

Right Hip:

Describes the hip pain as a dull achy pain 4/10 with upwards of 7/10 when aggravated. Aggravating factors includes walking.

Left Hip:

Describes the hip pain as a dull achy pain 4/10 with upwards of 7/10 when aggravated. Aggravating factors includes walking.

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

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

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

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

RIGHT HIP	LEFT HIP
3A. INITIAL ROM MEASUREMENTS	3A. INITIAL ROM MEASUREMENTS
[ ] All Normal [X] Abnormal or outside of normal range	[ ] All Normal [X] Abnormal or outside of normal range
[ ] Unable to test [ ] Not indicated	[ ] Unable to test [ ] 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 hip/thigh condition, such as age, body habitus, neurologic disease), please describe:	If ROM is outside of "normal" range, but is normal for the Veteran (for reason other than a hip/thigh condition, such as age, body habitus, neurologic disease), please describe:

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If abnormal, does the range of motion itself contribute to a functional loss?
[X] YES [ ] NO (If "YES," please explain)

Describes the hip pain as a dull achy pain 4/10 with upwards of 7/10 when aggravated. Aggravating factors includes walking.

If abnormal, does the range of motion itself contribute to a functional loss?
[X] YES [ ] NO (If "YES," please explain)

Describes the hip pain as a dull achy pain 4/10 with upwards of 7/10 when aggravated. Aggravating factors includes walking.

Note: For any joint condition, examiners should address pain on both passive and active motion, and on both weight-bearing and nonweight-bearing. Examiners should also test the contralateral joint (unless medically contraindicated). If testing cannot be performed or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation must be given below. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).

Can testing be performed? [ ] YES [ ] NO If "NO," provide an explanation:

If this is the unclaimed joint, is it: [ ] Damaged [ ] Undamaged

If undamaged, range of motion testing must be conducted.

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

Flexion endpoint (125 degrees)	90 degrees
Extension endpoint (30 degrees)	10 degrees
Abduction endpoint (45 degrees)	10 degrees
Adduction endpoint (25 degrees)	10 degrees
External rotation endpoint (60 degrees)	20 degrees
Internal rotation endpoint (40 degrees)	30 degrees

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

[X] Flexion [X] Abduction [X] External Rotation
[X] Extension [X] Adduction [X] Internal Rotation

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

____ Flexion degree endpoint (if different than above)
____ Adduction degree endpoint (if different than above)
____ Extension degree endpoint (if different than above)
____ External Rotation degree endpoint (if different than above)
____ Abduction degree endpoint (if different than above)
____ Internal Rotation degree endpoint (if different than above)

Can testing be performed? [ ] YES [ ] NO If "NO," provide an explanation:

If this is the unclaimed joint, is it: [ ] Damaged [ ] Undamaged

If undamaged, range of motion testing must be conducted.

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

Flexion endpoint (125 degrees)	90 degrees
Extension endpoint (30 degrees)	10 degrees
Abduction endpoint (45 degrees)	10 degrees
Adduction endpoint (25 degrees)	10 degrees
External rotation endpoint (60 degrees)	15 degrees
Internal rotation endpoint (40 degrees)	30 degrees

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

[X] Flexion [X] Abduction [X] External Rotation
[X] Extension [X] Adduction [X] Internal Rotation

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

____ Flexion degree endpoint (if different than above)
____ Adduction degree endpoint (if different than above)
____ Extension degree endpoint (if different than above)
____ External Rotation degree endpoint (if different than above)
____ Abduction degree endpoint (if different than above)
____ Internal Rotation degree endpoint (if different than above)

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Does a limitation in adduction prevent the Veteran from crossing his/her legs?
☐ YES ☒ NO

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

Flexion endpoint (125 degrees)	____ degrees	☐ Same as active ROM
Extension endpoint (30 degrees)	____ degrees	☐ Same as active ROM
Abduction endpoint (45 degrees)	____ degrees	☐ Same as active ROM
Adduction endpoint (25 degrees)	____ degrees	☐ Same as active ROM
External rotation endpoint (60 degrees)	____ degrees	☐ Same as active ROM
Internal rotation endpoint (40 degrees)	____ degrees	☐ Same as active ROM

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

☐ Flexion ☐ Abduction ☐ External Rotation
☐ Extension ☐ Adduction ☐ Internal Rotation

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

____ Flexion degree endpoint (if different than above)
____ Adduction degree endpoint (if different than above)
____ Extension degree endpoint (if different than above)
____ External Rotation degree endpoint (if different than above)
____ Abduction degree endpoint (if different than above)
____ Internal Rotation degree endpoint (if different than above)

Does a limitation in passive adduction prevent the Veteran from crossing his/her legs? ☐ YES ☐ NO

Is there evidence of pain? ☒ YES ☐ NO (If "YES," please explain)

☒ weight-bearing ☐ nonweight-bearing

☒ active motion ☐ passive motion ☐ on rest/non-movement

☒ causes functional loss (if checked describe in the comments box below) ☐ does not result in/cause functional loss

Comments:

Describes the hip pain as a dull achy pain 4/10 with upwards of 7/10 when aggravated. Aggravating factors includes walking.

Does a limitation in adduction prevent the Veteran from crossing his/her legs?
☐ YES ☒ NO

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

Flexion endpoint (125 degrees)	____ degrees	☐ Same as active ROM
Extension endpoint (30 degrees)	____ degrees	☐ Same as active ROM
Abduction endpoint (45 degrees)	____ degrees	☐ Same as active ROM
Adduction endpoint (25 degrees)	____ degrees	☐ Same as active ROM
External rotation endpoint (60 degrees)	____ degrees	☐ Same as active ROM
Internal rotation endpoint (40 degrees)	____ degrees	☐ Same as active ROM

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

☐ Flexion ☐ Abduction ☐ External Rotation
☐ Extension ☐ Adduction ☐ Internal Rotation

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

____ Flexion degree endpoint (if different than above)
____ Adduction degree endpoint (if different than above)
____ Extension degree endpoint (if different than above)
____ External Rotation degree endpoint (if different than above)
____ Abduction degree endpoint (if different than above)
____ Internal Rotation degree endpoint (if different than above)

Does a limitation in passive adduction prevent the Veteran from crossing his/her legs? ☐ YES ☐ NO

Is there evidence of pain? ☒ YES ☐ NO (If "YES," please explain)

☒ weight-bearing ☐ nonweight-bearing

☒ active motion ☐ passive motion ☐ on rest/non-movement

☒ causes functional loss (if checked describe in the comments box below) ☐ does not result in/cause functional loss

Comments:

Describes the hip pain as a dull achy pain 4/10 with upwards of 7/10 when aggravated. Aggravating factors includes walking.

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Is there objective evidence of crepitus? ☐ YES ☒ NO

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? ☒ YES ☐ NO If "YES," please explain. Include location, severity, and relationship to condition(s).

Description:
tenderness to palpation

Location:
anterolateral hip

Severity:
mild

Relationship to claimed condition:
Directly related to claimed condition

Is there objective evidence of crepitus? ☐ YES ☒ NO

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? ☒ YES ☐ NO If "YES," please explain. Include location, severity, and relationship to condition(s).

Description:
tenderness to palpation

Location:
anterolateral hip

Severity:
mild

Relationship to claimed condition:
Directly related to claimed condition

3B. OBSERVED REPETITIVE USE ROM

Is the Veteran able to perform repetitive-use testing with at least three repetitions? ☒ YES ☐ NO (If "NO," please explain)

Is there additional loss of function or range of motion after three repetitions?
☐ YES ☒ NO

If "YES," please respond to the following after the completion of the three repetitions:

Flexion endpoint (125 degrees)	____ degrees
Extension endpoint (30 degrees)	____ degrees
Abduction endpoint (45 degrees)	____ degrees
Adduction endpoint (25 degrees)	____ degrees

3B. OBSERVED REPETITIVE USE ROM

Is the Veteran able to perform repetitive-use testing with at least three repetitions? ☒ YES ☐ NO (If "NO," please explain)

Is there additional loss of function or range of motion after three repetitions?
☐ YES ☒ NO

If "YES," please respond to the following after the completion of the three repetitions:

Flexion endpoint (125 degrees)	____ degrees
Extension endpoint (30 degrees)	____ degrees
Abduction endpoint (45 degrees)	____ degrees
Adduction endpoint (25 degrees)	____ degrees

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External rotation endpoint (60 degrees) ____ degrees

Internal rotation endpoint (40 degrees) ____ degrees

Does limitation in adduction after observed repetitive use prevent the Veteran from crossing his/her legs? ☐ YES ☐ NO

Select factors that cause this functional loss: (check all that apply)

☐ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance
☐ Incoordination ☒ N/A ☐ Other:

External rotation endpoint (60 degrees) ____ degrees

Internal rotation endpoint (40 degrees) ____ degrees

Does limitation in adduction after observed repetitive use prevent the Veteran from crossing his/her legs? ☐ YES ☐ NO

Select factors that cause this functional loss: (check all that apply)

☐ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance
☐ Incoordination ☒ N/A ☐ Other:

Note: When pain is associated with movement, the examiner must give a statement on whether pain could significantly limit functional ability during flare-ups and/or after repeated use over time in terms of additional loss of range of motion. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare-ups - even if not directly observed during a flare-up and/or after repeated use over time.

3C. REPEATED USE OVER TIME

Is the Veteran being examined immediately after repeated use over time?
☐ YES ☒ NO

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time? ☒ YES ☐ NO

Select factors that cause this functional loss: (check all that apply)

☒ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance
☐ Incoordination ☐ N/A ☐ Other:

Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran.

Flexion endpoint (125 degrees) 90 degrees

Extension endpoint (30 degrees) 10 degrees

Abduction endpoint (45 degrees) 10 degrees

Adduction endpoint (25 degrees) 10 degrees

External rotation endpoint (60 degrees) 20 degrees

Internal rotation endpoint (40 degrees) 30 degrees

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)

Does limitation in adduction after repeated use over time prevent the Veteran from crossing his/her legs? ☐ YES ☒ NO

3C. REPEATED USE OVER TIME

Is the Veteran being examined immediately after repeated use over time?
☐ YES ☒ NO

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time? ☒ YES ☐ NO

Select factors that cause this functional loss: (check all that apply)

☒ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance
☐ Incoordination ☐ N/A ☐ Other:

Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran.

Flexion endpoint (125 degrees) 90 degrees

Extension endpoint (30 degrees) 10 degrees

Abduction endpoint (45 degrees) 10 degrees

Adduction endpoint (25 degrees) 10 degrees

External rotation endpoint (60 degrees) 15 degrees

Internal rotation endpoint (40 degrees) 30 degrees

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)

Does limitation in adduction after repeated use over time prevent the Veteran from crossing his/her legs? ☐ YES ☒ NO

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3D. FLARE-UPS

Is the examination being conducted during a flare-up? ☐ YES ☒ NO

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare-ups? ☐ YES ☒ NO

Select factors that cause this functional loss: (check all that apply)

☐ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance
☐ Incoordination ☒ N/A ☐ Other:

Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran.

Flexion endpoint (125 degrees)	____ degrees
Extension endpoint (30 degrees)	____ degrees
Abduction endpoint (45 degrees)	____ degrees
Adduction endpoint (25 degrees)	____ degrees
External rotation endpoint (60 degrees)	____ degrees
Internal rotation endpoint (40 degrees)	____ degrees

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)

The Veteran denies flare ups.

Does limitation in adduction during flare-ups prevent the Veteran from crossing his/her legs? ☐ YES ☐ NO

3E. ADDITIONAL FACTORS CONTRIBUTING TO DISABILITY

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:

☐ None ☐ Interference with sitting
☐ Interference with standing ☐ Swelling
☒ Disturbance of locomotion ☐ Deformity
☒ Less movement than normal ☐ More movement than normal
☐ Weakened movement ☐ Atrophy of disuse
☐ Instability of station ☐ Other, describe:

3D. FLARE-UPS

Is the examination being conducted during a flare-up? ☐ YES ☒ NO

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare-ups? ☐ YES ☒ NO

Select factors that cause this functional loss: (check all that apply)

☐ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance
☐ Incoordination ☒ N/A ☐ Other:

Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran.

Flexion endpoint (125 degrees)	____ degrees
Extension endpoint (30 degrees)	____ degrees
Abduction endpoint (45 degrees)	____ degrees
Adduction endpoint (25 degrees)	____ degrees
External rotation endpoint (60 degrees)	____ degrees
Internal rotation endpoint (40 degrees)	____ degrees

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)

The Veteran denies flare ups.

Does limitation in adduction during flare-ups prevent the Veteran from crossing his/her legs? ☐ YES ☐ NO

3E. ADDITIONAL FACTORS CONTRIBUTING TO DISABILITY

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:

☐ None ☐ Interference with sitting
☐ Interference with standing ☐ Swelling
☒ Disturbance of locomotion ☐ Deformity
☒ Less movement than normal ☐ More movement than normal
☐ Weakened movement ☐ Atrophy of disuse
☐ Instability of station ☐ Other, describe:

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Please describe additional contributing factors of disability:	Please describe additional contributing factors of disability:
Less movement than normal: decreased ROM	Less movement than normal decreased ROM

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Please describe additional contributing factors of disability (Cont.)	Please describe additional contributing factors of disability (Cont.)
Disturbance of locomotion: Aggravating factors includes walking.	Disturbance of locomotion: Aggravating factors includes walking.

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SECTION IV - MUSCLE ATROPHY

RIGHT HIP	LEFT HIP
4A. DOES THE VETERAN HAVE MUSCLE ATROPHY? ☐ YES ☒ NO	4A DOES THE VETERAN HAVE MUSCLE ATROPHY? ☐ YES ☒ NO
4B. IF "YES," IS THE MUSCLE ATROPHY DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION? ☐ YES ☐ NO IF "NO," PROVIDE RATIONALE:	4B. IF "YES," IS THE MUSCLE ATROPHY DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION? ☐ YES ☐ NO IF "NO," PROVIDE RATIONALE:
4C. FOR ANY MUSCLE ATROPHY DUE TO A DIAGNOSIS LISTED IN SECTION I, INDICATE SPECIFIC LOCATION OF ATROPHY, PROVIDING MEASUREMENTS IN CENTIMETERS OF NORMAL SIDE AND CORRESPONDING ATROPHIED SIDE, MEASURED AT MAXIMUM MUSCLE BULK. ☐ Right lower extremity (specify location of measurement such as "10cm above or below the hip"): Circumference of more normal side: _____ cm Circumference of atrophied side: _____ cm	4C. FOR ANY MUSCLE ATROPHY DUE TO A DIAGNOSIS LISTED IN SECTION I, INDICATE SPECIFIC LOCATION OF ATROPHY, PROVIDING MEASUREMENTS IN CENTIMETERS OF NORMAL SIDE AND CORRESPONDING ATROPHIED SIDE, MEASURED AT MAXIMUM MUSCLE BULK. ☐ Left lower extremity (specify location of measurement such as "10cm above or below the hip"): Circumference of more normal side: _____ cm Circumference of atrophied side: _____ cm

SECTION V - ANKYLOSIS

RIGHT HIP	LEFT HIP
NOTE: Ankylosis is the immobilization of a joint due to disease, injury, or surgical procedure.	
5A. IS THERE ANKYLOSIS OF THE HIP AND/OR THIGH? ☐ YES ☒ NO IF "YES," INDICATE THE SEVERITY OF ANKYLOSIS: ☐ Unfavorable, extremely unfavorable ankylosis, foot not reaching ground, crutches needed ☐ Intermediate, between favorable and unfavorable ☐ Favorable, in flexion at an angle between 20 and 40 degrees, and slight abduction or adduction	5A. IS THERE ANKYLOSIS OF THE HIP AND/OR THIGH? ☐ YES ☒ NO IF "YES," INDICATE THE SEVERITY OF ANKYLOSIS: ☐ Unfavorable, extremely unfavorable ankylosis, foot not reaching ground, crutches needed ☐ Intermediate, between favorable and unfavorable ☐ Favorable, in flexion at an angle between 20 and 40 degrees, and slight abduction or adduction

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SECTION VI - FEMUR OR FLAIL HIP JOINT IMPAIRMENT

NOTE: If impairment of the femur causes an associated knee disability, please complete the additional appropriate questionnaire.

RIGHT HIP

6A. DOES THE VETERAN HAVE MALUNION OR NON UNION OF FEMUR, FLAIL HIP JOINT OR LEG LENGTH DISCREPANCY? ☐ YES ☒ NO

- ☐ Fracture of shaft or neck (anatomical), with nonunion with loose motion (spiral or oblique fracture)
- ☐ Fracture of shaft or neck (anatomical), resulting in nonunion without loose motion; weight-bearing preserved with aid of brace
- ☐ Fracture of surgical neck with false joint
- ☐ Malunion of the femur
- ☐ Flail hip joint
- ☐ Leg length discrepancy (shortening of any bones of the lower extremity) (If checked, provide length of each lower extremity in inches (to the nearest 1/4 inch) or centimeters measuring from the anterior superior iliac spine to the internal malleolas of the tibia.)

Measurements: Right leg: _____ ☐ cm ☐ inch

For any leg length discrepancy, please describe the relationship to the conditions listed in the diagnosis section above:

LEFT HIP

6A. DOES THE VETERAN HAVE MALUNION OR NON UNION OF FEMUR, FLAIL HIP JOINT OR LEG LENGTH DISCREPANCY? ☐ YES ☒ NO

- ☐ Fracture of shaft or neck (anatomical), with nonunion with loose motion (spiral or oblique fracture)
- ☐ Fracture of shaft or neck (anatomical), resulting in nonunion without loose motion; weight-bearing preserved with aid of brace
- ☐ Fracture of surgical neck with false joint
- ☐ Malunion of the femur
- ☐ Flail hip joint
- ☐ Leg length discrepancy (shortening of any bones of the lower extremity) (If checked, provide length of each lower extremity in inches (to the nearest 1/4 inch) or centimeters measuring from the anterior superior iliac spine to the internal malleolas of the tibia.)

Measurements: Left leg: _____ ☐ cm ☐ inch

For any leg length discrepancy, please describe the relationship to the conditions listed in the diagnosis section above:

SECTION VII - SURGICAL PROCEDURES

RIGHT HIP

7A. INDICATE ANY SURGICAL PROCEDURES THAT THE VETERAN HAS HAD PERFORMED AND PROVIDE THE ADDITIONAL INFORMATION AS REQUESTED *(check all that apply):*

- ☒ No surgery
- ☐ Hip joint resurfacing Date of surgery: _____
- ☐ Total hip joint replacement Date of surgery: _____

Total hip joint replacement residuals:

- ☐ None
- ☐ Moderately severe residuals of weakness, pain or limitation of motion
- ☐ Markedly severe residuals of weakness, pain or limitation of motion following implantation of prosthesis
- ☐ Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches
- ☐ Other, describe:

LEFT HIP

7A. INDICATE ANY SURGICAL PROCEDURES THAT THE VETERAN HAS HAD PERFORMED AND PROVIDE THE ADDITIONAL INFORMATION AS REQUESTED *(check all that apply):*

- ☒ No surgery
- ☐ Hip joint resurfacing Date of surgery: _____
- ☐ Total hip joint replacement Date of surgery: _____

Total hip joint replacement residuals:

- ☐ None
- ☐ Moderately severe residuals of weakness, pain or limitation of motion
- ☐ Markedly severe residuals of weakness, pain or limitation of motion following implantation of prosthesis
- ☐ Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches
- ☐ Other, describe:

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☐ Arthroscopic ligament repair Date of surgery: _____	☐ Arthroscopic ligament repair Date of surgery: _____
☐ Other surgery not described (specify below): Date of surgery: Type of surgery:	☐ Other surgery not described (specify below): Date of surgery: Type of surgery:
☐ Residuals of arthroscopic or other hip surgery Describe residuals:	☐ Residuals of arthroscopic or other hip surgery Describe residuals:

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

8A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE? ☐ YES ☒ NO IF "YES," DESCRIBE *(brief summary)*

8B. DOES THE VETERAN HAVE ANY SCARS OR OTHER DISFIGUREMENT *(of the skin)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE? ☐ YES ☒ NO IF "YES," ALSO COMPLETE THE APPROPRIATE DERMATOLOGICAL QUESTIONNAIRE

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SECTION IX - ASSISTIVE DEVICES

9A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE? ☐ YES ☒ NO IF "YES,"IDENTIFY ASSISTIVE DEVICES USED *(check all that apply and indicate frequency)*:

☐ Wheelchair	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Bracing for ambulation	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Crutches	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant
☐ Other, describe:	Frequency of use: ☐ Occasional	☐ Regular	☐ Constant

9B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION, INDICATE THE SIDE, AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION X - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

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

10A. DUE TO THE VETERAN'S HIP OR THIGH CONDITION(S), IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTIONS REMAIN OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? *(Functions of the lower extremity include balance and propulsion, etc.)*

☐ YES, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.

☒ NO

If "YES," indicate extremities for which this applies: ☐ Right lower ☐ Left lower

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10B. FOR EACH CHECKED EXTREMITY, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, DESCRIBE LOSS OF EFFECTIVE FUNCTION AND PROVIDE SPECIFIC EXAMPLES *(brief summary)*:

SECTION XI - DIAGNOSTIC TESTING

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

11A. HAVE IMAGING STUDIES BEEN PERFORMED IN CONJUNCTION WITH THIS EXAMINATION?

☐ YES ☒ NO

11B. IF "YES," IS DEGENERATIVE OR POST-TRAUMATIC ARTHRITIS DOCUMENTED?

☐ YES ☐ NO

indicate side: ☐ Right ☐ Left ☐ Both

11C. IF "YES," PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS (*brief summary*):

11D. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS OR RESULTS RELATED TO THE CLAIMED CONDITION(S) AND/OR DIAGNOSIS(ES), THAT WERE REVIEWED IN CONJUNCTION WITH THIS EXAMINATION?

☐ YES ☒ NO

If "YES," provide type of test or procedure, date and results *(brief summary)*:

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11E. IF ANY TEST RESULTS ARE OTHER THAN NORMAL, INDICATE RELATIONSHIP OF ABNORMAL FINDINGS TO DIAGNOSED CONDITIONS:

SECTION XII - FUNCTIONAL IMPACT

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

12A. REGARDLESS OF THE VETERAN'S CURRENT EMPLOYMENT STATUS, DO THE CONDITION(S) LISTED IN THE DIAGNOSIS SECTION IMPACT HIS/HER ABILITY TO PERFORM ANY TYPE OF OCCUPATIONAL TASK *(such as standing, walking, lifting, sitting, etc.)*?

☒ YES ☐ NO

If "YES," describe the functional impact of each condition, providing one or more examples:

Current OR if retired/unemployed, previous occupation:

defense contractor

0-1 week work time lost in last 12 months

Veteran denies taking any days off due specifically to his hip pain, however will take breaks throughout the day as needed. Describes the hip pain as a dull achy pain 4/10 with upwards of 7/10 when aggravated. Aggravating factors includes walking.

SECTION XIII - REMARKS

13A. REMARKS (IF ANY – PLEASE IDENTIFY THE SECTION TO WHICH THE REMARK PERTAINS WHEN APPROPRIATE).

Passive ROM of right hip not performed.
Passive range of motion is medically contraindicated as it may cause the Veteran severe pain or the risk of further injury. It is not medically advisable to conduct passive range of motion testing because:
Passive ROM not evaluated due to potential to cause pain to veteran.

Passive ROM of left hip not performed.
Passive range of motion is medically contraindicated as it may cause the Veteran severe pain or the risk of further injury. It is not medically advisable to conduct passive range of motion testing because:
Passive ROM not performed due to potential to cause pain to veteran.

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REMARKS (*cont.*):
Is there a need for the Veteran/Service Member to follow up with his or her primary care provider regarding any life threatening or abnormal findings in this examination (not limited to claimed condition(s))? No

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REMARKS (*cont.*):

Section III: ROM: A goniometer was used to measure ROM.
Reason x-rays not needed or not performed:
X-rays on the day of exam were not clinically indicated.

For claim of bilateral hips, diagnosis of bilateral hip strain rendered day of exam due to decreased ROM.
Clarification: discrepancy during ROM for hip flexion bilaterally. Veteran had substantially decreased ROM noted on goniometer evaluation, however was able to sit down into chair and stand up. Thus, hip flexion ROM noted as 90.

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REMARKS (*cont.*):

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REMARKS (*cont.*):

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REMARKS (*cont.*):

Is the Veteran homeless? No

Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION XIV - EXAMINER'S CERTIFICATION AND SIGNATURE

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

14A. EXAMINER'S SIGNATURE	14B. EXAMINER'S PRINTED NAME	14C. DATE SIGNED
PA-C	Christine Ward Physician Assistant – General Practice	12/13/2023

14D. EXAMINER'S PHONE & FAX NUMBER	14E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	14F. MEDICAL LICENSE NUMBER AND STATE
910-238-4443 910-333-0203	1730111824	Lic: # 0010-09863, NC

14G. EXAMINER'S ADDRESS
34 Office Park Drive Suite 200 Jacksonville NC 28546

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HYPERTENSION
DISABILITY BENEFITS QUESTIONNAIRE

NAME OF CLAIMANT/VETERAN:	CLAIMANT/VETERAN'S SOCIAL SECURITY NUMBER:	DATE OF EXAMINATION:
Anthony Robert	*xxxxx*	12/13/2023

NOTE TO EXAMINER: The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA21-2507, C&P EXAMINATION REQUEST?

☒ Yes ☐ No

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

☒ In-person examination

☒ Records reviewed

☐ Examination via approved video telehealth

☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

EVIDENCE REVIEWED *(check all that apply):*

☐ Not requested ☐ No records were reviewed

☐ VA claims file (hard copy paper C-file)

☒ VA e-folder

☐ VA electronic health record

☐ Other (please identify other evidence reviewed):

Evidence Comments:

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN CURRENTLY HAVE A DIAGNOSIS OF HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION BASED ON THE FOLLOWING CRITERIA?

NOTE 1: For VA disability rating purposes, the term hypertension means that the diastolic blood pressure is predominantly 90mm or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm or greater with a diastolic blood pressure of less than 90mm.

NOTE 2: For VA purposes, the INITIAL diagnosis of hypertension or isolated systolic hypertension must be confirmed by readings taken 2 or more times on at least 3 different days. Blood pressure results may be obtained from existing medical records or through scheduled visits for blood pressure measurements.

☒ Yes ☐ No

(If "YES," provide only diagnoses that pertain to hypertension):

	ICD Code:	Date of diagnosis:
☒ Hypertension	I10	12/2023
☐ Isolated systolic hypertension		
☐ Other, specify: Other Diagnosis #1		

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Other Diagnosis #2		

1B. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION, LIST USING ABOVE FORMAT:

NOTE 3: ALSO complete appropriate questionnaires for hypertension-related complications, if any (such as Kidney, if renal insufficiency is attributable to hypertension).

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S HYPERTENSION CONDITION *(brief summary):*

Onset Date:
~ 2001

Details of Onset:
Veteran states during service he was notified his blood pressure was prehypertensive at that time.

Approximate date of diagnosis:
~ 2018

Date when medication first started:
~ 2018

Course:
Veteran states his blood pressure continued to rise until about 2018 when his prehypertension turned into hypertension. He has been placed on medication with good control since.

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION?

☒ Yes ☐ No

(If "YES," list only those medications used for the diagnosed conditions):

amlodipine 10mg daily

2C. WAS THE VETERAN'S INITIAL DIAGNOSIS OF HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION CONFIRMED BY BLOOD PRESSURE READINGS TAKEN 2 OR MORE TIMES ON AT LEAST 3 DIFFERENT DAYS?

☐ Yes ☐ No ☒ Unknown (If checked, proceed to questions 2D and 2E)

(If "YES," provide BP readings used to establish initial diagnosis, if known)

Reading #1: /	Reading #2: /	Date of Reading:
Reading #1: /	Reading #2: /	Date of Reading:
Reading #1: /	Reading #2: /	Date of Reading:

(If "NO," report BP readings taken 2 or more times on at least 3 different days in order to confirm diagnosis (unless Veteran is on treatment for hypertension.))

Reading #1: /	Reading #2: /	Date of Reading:
Reading #1: /	Reading #2: /	Date of Reading:
Reading #1: /	Reading #2: /	Date of Reading:

2D. DOES THE VETERAN HAVE A HISTORY OF A DIASTOLIC BP ELEVATION TO PREDOMINANTLY 100 OR MORE?

☐ Yes ☒ No

(If "YES," describe frequency and severity of diastolic BP elevation):

2E. CURRENT (DATE OF EVALUATION/S) BLOOD PRESSURE READINGS** (SUFFICIENT IF VETERAN HAS A PREVIOUSLY ESTABLISHED DIAGNOSIS OF HYPERTENSION):

Reading #1: 142 / 92	Date of Reading: 12/13/2023	**The Veteran should be seated comfortably with back and feet supported. There is no need to take lying or standing blood pressures. There is no specified time interval between readings and they may be completed sequentially.
Reading #2: 142 / 94	Date of Reading: 12/13/2023	
Reading #3: 144 / 96	Date of Reading: 12/13/2023	

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

3A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ Yes ☒ No

IF "YES," DESCRIBE *(brief summary):*

3B. DOES THE VETERAN HAVE ANY SCARS (SURGICAL OR OTHERWISE) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ Yes ☒ No

(IF "YES," ALSO COMPLETE APPROPRIATE DERMATOLOGICAL DBQ)

3C. COMMENTS, IF ANY:

SECTION IV - FUNCTIONAL IMPACT

4A. DOES THE VETERAN'S HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION IMPACT HIS OR HER ABILITY TO WORK?

☐ Yes ☒ No

(If "YES," describe the impact of the Veteran's hypertension or isolated systolic hypertension, providing one or more examples):

SECTION V - REMARKS

5A. REMARKS *(if any):*

Is there a need for the Veteran/Service Member to follow up with his or her primary care provider regarding any life threatening or abnormal findings in this examination (not limited to claimed condition(s))? Yes
If yes, was the Veteran/Service Member notified to follow up with his or her primary care provider? Yes
Reason to follow up with PCP:
Veteran encouraged to follow up with PCP due to elevated diastolic BP day of exam. Further encouraged to monitor his BP at home.
Was a copy of the test results identifying the life threatening or abnormal findings provided to the Veteran or the Veteran's primary care provider? Yes

Unable to find records that meet VA criteria of two blood pressures on the same day for three different days: diastolic > or = 90mmHG or isolated systolic > or = to 160mmHG. However, going through the veteran's claims file, there is sufficient documentation of elevated blood pressures and continued treatment for hypertension over the years. Therefore rendering a diagnosis of hypertension day of exam.

Is the Veteran homeless? No
Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION VI - EXAMINER'S CERTIFICATION AND SIGNATURE

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

6A. EXAMINER'S SIGNATURE:	6B. EXAMINER'S PRINTED NAME:	6C. DATE SIGNED:
PA-C	Christine Ward Physician Assistant – General Practice	12/13/2023
6D. EXAMINER'S PHONE AND FAX NUMBER:	**6E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER:**	**6F. MEDICAL LICENSE NUMBER AND STATE:**
910-238-4443 910-333-0203	1730111824	0010-09863, NC

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6G. EXAMINER'S ADDRESS:
34 Office Park Drive Suite 200 Jacksonville NC 28546

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MEDICAL OPINION
DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT – THE DEPARTMENT OF VETERAN'S AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN:	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER:	EXAMINATION DATE:
Anthony Robert	*xxxxx*	12/13/2023

Note to examiner **-** The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

Is this questionnaire being completed in conjunction with VA 21-2507, C&P examination request?

☒ Yes ☐ No

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

☒ In-person examination

☒ Records reviewed

☐ Examination via approved video telehealth

☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

Indicate the method used to obtain medical information to complete this document:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

Evidence Reviewed (check all that apply):

☐ No records were reviewed

☐ Not requested

☐ VA claims file (hard copy paper C-file)

☒ VA e-folder

☐ VA electronic health record

☐ Other, please identify other evidence reviewed:

Evidence Comments:

Pg 144: entrance exam 6/1998. No medical conditions noted. BP 126/75
Pg 151: separation exam ?4/2002 reviewed. No medical conditions noted. BP 127/79
Pg 746: sleep medicine consult note 8/2018. Noted PMH of hypertension. Diagnosis of sleep apnea with AHI of 32 per WatchPat. Further noted diagnosis of overweight/mild obesity and hypertension. Noted family history of sleep apnea including father and paternal uncle.
Pg 741: PCP note 8/2020 with diagnosis of hypertension – on treatment from outside physician.
Pg 799: PCP note 2/2022 with diagnosis of hypertension and bilateral knee pain (previously diagnosis patellofemoral syndrome)

SECTION I - DEFINITIONS

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

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

SECTION II - RESTATEMENT OF REQUESTED OPINION

2a. Insert requested opinion from general remarks:
Is the Veteran's High blood pressure at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or the result of: Sleep apnea

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2b. Indicate type of exam for which opinion has been requested *(e.g. Skin Diseases)*:
DBQ CARDIO Hypertension

SECTION III – MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

Choose the statement that most closely approximates the etiology of this claimed condition.

☐ 3a. The claimed condition was at least as likely as not *(likelihood is at least approximately balanced or nearly equal, if not higher)* incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section C.

☐ 3b. The claimed condition was less likely than not *(likelihood is less than approximately balanced or nearly equal)* incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section C.

3c. Rationale:

SECTION IV – MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

☐ 4a. The claimed condition is at least as likely as not *(likelihood is at least approximately balanced or nearly equal, if not higher)* proximately due to or the result of the Veteran's service connected condition. Provide rationale in section C.

☒ 4b. The claimed condition is less likely than not *(likelihood is less than approximately balanced or nearly equal)* proximately due to or the result of Veteran's service connected condition. Provide rationale in section C.

4c. Rationale:
For the claim of high blood pressure with diagnosis of hypertension, it is less likely than not due to veteran's claimed condition of sleep apnea. The veteran was evaluated and treated for sleep apnea in 2018. At that time of sleep study/evaluation, the veteran already held the diagnosis of hypertension. Therefore, it is less likely than not the veteran's hypertension is due to sleep apnea as the hypertension preexisted the formal sleep apnea diagnosis. A nexus has not been established.

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

☐ 5a. The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section C.

☐ 5b. The claimed condition, which clearly and unmistakably existed prior to service, was clearly and unmistakably not aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section C.

5c. Rationale:

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

6a. Can you determine a baseline level of severity of *(claimed condition/diagnosis)* based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by *(service connected condition)*?

☐ Yes ☐ No

If "YES" to question 6a, answer the following:

i. Describe the baseline level of severity of *(claimed condition/diagnosis)* based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by *(service connected condition)*:

ii. Provide the date and nature of the medical evidence used to provide the baseline:

iii. Is The current severity of the *(claimed condition/diagnosis)* greater than the baseline?
☐ Yes ☐ No

If YES, was the Veteran's *(claimed condition/diagnosis)* at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?
☐ Yes ☐ No *(provide rationale in section 6B.)*

If "NO" to question 6a, answer the following:

i. Provide rationale as to why a baseline cannot be established *(e.g. medical evidence is not sufficient to support a determination of a baseline level of*

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severity):

ii. Regardless of an established baseline, was the Veteran's *(claimed condition/diagnosis)* at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?

☐ Yes ☐ No *(provide rationale in section 6B.)*

6b. Provide rationale:

SECTION VII - MEDICAL OPINION FOR TOXIC EXPOSURE RISK ACTIVITIES

Choose the statement that most closely approximates the etiology of this claimed condition.

☐ 7a. The claimed condition was at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) caused by the indicated toxic exposure risk activity(ies), after considering the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran. Provide rationale in section C.

☐ 7b. The claimed condition was less likely than not (likelihood is less than approximately balanced or nearly equal) caused by the indicated toxic exposure risk activity(ies), after considering the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran. Provide rationale in section C.

7c. Provide rationale:

SECTION VIII - OPINION REGARDING CONFLICTING MEDICAL EVIDENCE

8. I have reviewed the conflicting medical evidence and am providing the following opinion:

Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION IX – PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9a. PHYSICIAN'S SIGNATURE	9b. PHYSICIAN'S PRINTED NAME	9c. DATE SIGNED
PA-C	Christine Ward Physician Assistant – General Practice	12/13/2023

9d. PHYSICIAN'S PHONE/FAX NUMBERS	9e. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	9f. PHYSICIAN'S ADDRESS
910-238-4443 910-333-0203	1730111824 Lic. #: 0010-09863, NC	34 Office Park Drive Suite 200 Jacksonville NC 28546

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KNEE AND LOWER LEG CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

NAME OF CLAIMANT/VETERAN:	CLAIMANT/VETERAN'S SOCIAL SECURITY NUMBER:	DATE OF EXAMINATION:
Anthony Robert	*xxxxx*	12/13/2023

NOTE TO EXAMINER: The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA21-2507, C&P EXAMINATION REQUEST? ☒ YES ☐ NO

HOW WAS THE EXAMINATION COMPLETED (CHECK ALL THAT APPLY)?

- ☒ In-person examination
- ☒ Records reviewed
- ☐ Examination via approved video telehealth
- ☐ Other, please specify the comments box

COMMENTS:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

- ☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.
- ☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

Evidence Reviewed (check all that apply):

- ☐ No Records were Reviewed
- ☐ Not Requested
- ☐ VA claims file (hard copy paper C-file)
- ☒ VA e-folder
- ☐ VA electronic health record
- ☐ Other (please identify other evidence reviewed):

Evidence Comments:

SECTION I - DIAGNOSIS

NOTE: These are condition(s) for which an evaluation has been requested on an exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. LIST THE CLAIMED CONDITION(S) THAT PERTAIN TO THIS DBQ:

bilateral knee condition to include patellofemoral pain syndrome

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.

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1B. SELECT DIAGNOSES ASSOCIATED WITH THE CLAIMED CONDITION(S) *(Check all that apply):*

☐ The Veteran does not have a current diagnosis associated with any claimed condition listed above. *(Explain your findings and reasons in the remarks section).*

	Side affected:			ICD Code:	Date of Diagnosis:	
	Right	Left	Both		Right	Left
☐ Knee strain	☐	☐	☐			
☐ Knee meniscal tear	☐	☐	☐			
☐ Knee anterior cruciate ligament tear	☐	☐	☐			
☐ Knee posterior cruciate ligament tear	☐	☐	☐			
☐ Patellar or quadriceps tendon rupture	☐	☐	☐			
☐ Knee joint osteoarthritis	☐	☐	☐			
☐ Knee joint ankylosis	☐	☐	☐			
☐ Knee fracture (including patellar fracture)	☐	☐	☐			
☐ Stress fracture of tibia	☐	☐	☐			
☐ Tibia and/or Fibula fracture	☐	☐	☐			
☐ Recurrent patellar dislocation	☐	☐	☐			
☐ Recurrent subluxation	☐	☐	☐			
☐ Knee instability	☐	☐	☐			
☐ Patellar instability	☐	☐	☐			
☐ Knee cartilage restoration surgery	☐	☐	☐			
☐ Shin splints *(If diagnosed with compartment syndrome complete the Muscles questionnaire in lieu of this questionnaire)*	☐	☐	☐			
☒ Patellofemoral pain syndrome	☐	☐	☒	M25.569	2002	2002
☐ Degenerative arthritis, other than Post-traumatic	☐	☐	☐			
☐ Arthritis, gonorrheal	☐	☐	☐			
☐ Arthritis, pneumococcic	☐	☐	☐			
☐ Arthritis, streptococcic	☐	☐	☐			
☐ Arthritis, syphilitic	☐	☐	☐			
☐ Arthritis, rheumatoid (multi-joints)	☐	☐	☐			
☐ Post-traumatic arthritis	☐	☐	☐			
☐ Arthritis, typhoid	☐	☐	☐			
☐ Other specified forms of arthropathy (excluding gout) (specify)	☐	☐	☐			
☐ Osteoporosis, residuals of	☐	☐	☐			
☐ Osteomalacia, residuals of	☐	☐	☐			
☐ Bones, neoplasm, benign	☐	☐	☐			
☐ Osteitis deformans	☐	☐	☐			
☐ Gout	☐	☐	☐			
☐ Bursitis	☐	☐	☐			
☐ Myositis	☐	☐	☐			
☐ Heterotopic ossification	☐	☐	☐			
☐ Tendinopathy (select one if known)	☐	☐	☐			
☐ Tendinitis	☐	☐	☐			
☐ Tendinosis	☐	☐	☐			
☐ Tenosynovitis	☐	☐	☐			

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	Side affected: Right	Left	Both	ICD Code:	Date of Diagnosis: Right	Left
☐ Inflammatory, other types *(specify)*	☐	☐	☐			
☐ Other *(specify)*:						
Other diagnosis #1:	☐	☐	☐			
Other diagnosis #2:	☐	☐	☐			
Other diagnosis #3:	☐	☐	☐			

If there are additional diagnoses that pertain to knee and lower leg 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)*:

Onset Date:

~ 1999

Details of Onset:

Veteran states his knees were "smashed into his dashboard" during his MVA during service. Further notes prior to accidents he as involved in the navy honor guard where he had to stand at attention for hours at a time, which aggravated his knee pain.

Course since Onset:

Veteran states his knee pain has worsened over the years. Describes his bilateral knee pain as an achy 6-7/10 pain underneath his patella with increase in intensity to 10/10 when aggravated. Aggravating factors includes sitting >60 min, kneeling, walking >7-10min, stairs. Further admits to mild swelling daily by the end of the day.

Current Symptoms:

Describes his bilateral knee pain as an achy 6-7/10 pain underneath his patella with increase in intensity to 10/10 when aggravated. Aggravating factors includes sitting >60 min, kneeling, walking >7-10min, stairs. Further admits to mild swelling daily by the end of the day.

Current Treatment and Frequency:

ibuprofen, naproxen prn. No formal therapy.

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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 or her own words.

Right Knee:

Describes his bilateral knee pain as an achy 6-7/10 pain underneath his patella with increase in intensity to 10/10 when aggravated. Aggravating factors includes sitting >60 min, kneeling, walking >7-10min, stairs. Further admits to mild swelling daily by the end of the day.

Left Knee:

Describes his bilateral knee pain as an achy 6-7/10 pain underneath his patella with increase in intensity to 10/10 when aggravated. Aggravating factors includes sitting >60 min, kneeling, walking >7-10min, stairs. Further admits to mild swelling daily by the end of the day.

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.

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:

Right Knee:

Further admits to mild swelling daily by the end of the day.

Left Knee:

Further admits to mild swelling daily by the end of the day.

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SECTION III - INITIAL 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 ☐ All Normal ☒ Abnormal or outside of normal range ☐ Unable to test ☐ Not indicated If "Unable to test" or "Not indicated" please explain:	3A. INITIAL ROM MEASUREMENTS ☐ All Normal ☒ Abnormal or outside of normal range ☐ Unable to test ☐ Not indicated If "Unable to test" or "Not indicated" please explain:
If ROM is outside of "normal" range, but is normal for the Veteran (for 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) ☒ YES ☐ NO Describes his bilateral knee pain as an achy 6-7/10 pain underneath his patella with increase in intensity to 10/10 when aggravated. Aggravating factors includes sitting >60 min, kneeling, walking >7-10min, stairs. Further admits to mild swelling daily by the end of the day.	If abnormal, does the range of motion itself contribute to a functional loss? (If "YES," please explain) ☒ YES ☐ NO Describes his bilateral knee pain as an achy 6-7/10 pain underneath his patella with increase in intensity to 10/10 when aggravated. Aggravating factors includes sitting >60 min, kneeling, walking >7-10min, stairs. Further admits to mild swelling daily by the end of the day.

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).

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Can testing be performed?
☐ YES ☐ NO
If "NO," provide an explanation:

If this is the unclaimed joint, is it:
☐ Damaged ☐ Undamaged

If undamaged, range of motion testing must be conducted.

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

Flexion endpoint (140 degrees): 110 degrees

Extension endpoint (0 degrees): 0 degrees

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

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

_____ Flexion degree endpoint (if different than above)

_____ Extension degree endpoint (if different than above)

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

Flexion endpoint (140 degrees): _____ degrees ☐ Same as active ROM

Extension endpoint (0 degrees): _____ degrees ☐ Same as active ROM

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

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

_____ Flexion degree endpoint (if different than above)

_____ Extension degree endpoint (if different than above)

Can testing be performed?
☐ YES ☐ NO
If "NO," provide an explanation:

If this is the unclaimed joint, is it:
☐ Damaged ☐ Undamaged

If undamaged, range of motion testing must be conducted.

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

Flexion endpoint (140 degrees): 90 degrees

Extension endpoint (0 degrees): 0 degrees

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

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

_____ Flexion degree endpoint (if different than above)

_____ Extension degree endpoint (if different than above)

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

Flexion endpoint (140 degrees): _____ degrees ☐ Same as active ROM

Extension endpoint (0 degrees): _____ degrees ☐ Same as active ROM

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

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

_____ Flexion degree endpoint (if different than above)

_____ Extension degree endpoint (if different than above)

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Is there evidence of pain?
[X] YES [ ] NO
If "YES," check all that apply.

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

Comments:
Describes his bilateral knee pain as an achy 6-7/10 pain underneath his patella with increase in intensity to 10/10 when aggravated. Aggravating factors includes sitting >60 min, kneeling, walking >7-10min, stairs. Further admits to mild swelling daily by the end of the day.

Is there objective evidence of crepitus?
[ ] YES [X] NO

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?
[X] YES [ ] NO
If "YES," please explain. Include location, severity, and relationship to condition(s).

Describe:
tenderness to palpation

Location:
medial and inferior aspect of knee

Is there evidence of pain?
[X] YES [ ] NO
If "YES," check all that apply.

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

Comments:
Describes his bilateral knee pain as an achy 6-7/10 pain underneath his patella with increase in intensity to 10/10 when aggravated. Aggravating factors includes sitting >60 min, kneeling, walking >7-10min, stairs. Further admits to mild swelling daily by the end of the day.

Is there objective evidence of crepitus?
[ ] YES [X] NO

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?
[X] YES [ ] NO
If "YES," please explain. Include location, severity, and relationship to condition(s).

Describe:
tenderness to palpation

Location:
medial and inferior aspect of knee

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Severity: mild Relationship to claimed condition: Directly related to claimed condition	Severity: mild Relationship to claimed condition: Directly related to claimed condition
RIGHT KNEE	LEFT KNEE
3B. OBSERVED REPETITIVE USE ROM Is the Veteran able to perform repetitive-use testing with at least three repetitions? ☒ YES ☐ NO If "NO," please explain: Is there additional loss of function or range of motion after three repetitions? ☐ YES ☒ NO If "YES," please respond to the following after the completion of the three repetitions: Flexion endpoint (140 degrees): _____ degrees Extension endpoint (0 degrees): _____ degrees Select factors that cause this functional loss: (check all that apply) ☐ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance ☐ Incoordination ☒ N/A ☐ Other	3B. OBSERVED REPETITIVE USE ROM Is the Veteran able to perform repetitive-use testing with at least three repetitions? ☒ YES ☐ NO If "NO," please explain: Is there additional loss of function or range of motion after three repetitions? ☐ YES ☒ NO If "YES," please respond to the following after the completion of the three repetitions: Flexion endpoint (140 degrees): _____ degrees Extension endpoint (0 degrees): _____ degrees Select factors that cause this functional loss: (check all that apply) ☐ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance ☐ Incoordination ☒ N/A ☐ Other

Note: When pain is associated with movement, the examiner must give a statement on whether pain could significantly limit functional ability during flare-ups and/or after repeated use over time in terms of additional loss of range of motion. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare-ups - even if not directly observed during a flare-up and/or after repeated use over time.

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RIGHT KNEE	LEFT KNEE
3C. REPEATED USE OVER TIME	3C. REPEATED USE OVER TIME
Is the Veteran being examined immediately after repeated use over time? ☐ YES ☒ NO	Is the Veteran being examined immediately after repeated use over time? ☐ YES ☒ NO
Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time? ☒ YES ☐ NO	Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time? ☒ YES ☐ NO
Select factors that cause this functional loss: (check all that apply) ☒ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance ☐ Incoordination ☐ N/A ☐ Other	Select factors that cause this functional loss: (check all that apply) ☒ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance ☐ Incoordination ☐ N/A ☐ Other
Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran.	Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran.
Flexion endpoint (140 degrees): 100 degrees	Flexion endpoint (140 degrees): 85 degrees
Extension endpoint (0 degrees): 10 degrees	Extension endpoint (0 degrees): 10 degrees
The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.	The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.
Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)	Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)

RIGHT KNEE	LEFT KNEE
3D. FLARE-UPS	3D. FLARE-UPS
Is the examination being conducted during a flare-up? ☐ YES ☒ NO	Is the examination being conducted during a flare-up? ☐ YES ☒ NO
Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare-ups? ☐ YES ☒ NO	Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare-ups? ☐ YES ☒ NO
Select factors that cause this functional loss: (check all that apply) ☐ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance ☐ Incoordination ☒ N/A ☐ Other	Select factors that cause this functional loss: (check all that apply) ☐ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance ☐ Incoordination ☒ N/A ☐ Other
Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran.	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.

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Flexion endpoint (140 degrees): _____ degrees

Extension endpoint (0 degrees): _____ degrees

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)

The Veteran denies flare ups.

Flexion endpoint (140 degrees): _____ degrees

Extension endpoint (0 degrees): _____ degrees

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)

The Veteran denies flare ups.

RIGHT KNEE

3E. ADDITIONAL FACTORS CONTRIBUTING TO DISABILITY

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:

- [ ] None
- [ ] Interference with standing
- [X] Disturbance of locomotion
- [X] Less movement than normal
- [ ] Weakened movement
- [ ] Instability of station
- [ ] Other, describe:
- [X] Interference with sitting
- [X] Swelling
- [ ] Deformity
- [ ] More movement than normal (indicate if there is nonunion of fracture)
  - [ ] nonunion of fracture
- [ ] Atrophy of disuse

Please describe additional contributing factors of disability:

Less movement than normal:

decreased ROM

LEFT KNEE

3E. ADDITIONAL FACTORS CONTRIBUTING TO DISABILITY

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:

- [ ] None
- [ ] Interference with standing
- [X] Disturbance of locomotion
- [X] Less movement than normal
- [ ] Weakened movement
- [ ] Instability of station
- [ ] Other, describe:
- [X] Interference with sitting
- [X] Swelling
- [ ] Deformity
- [ ] More movement than normal (indicate if there is nonunion of fracture)
  - [ ] nonunion of fracture
- [ ] Atrophy of disuse

Please describe additional contributing factors of disability:

Less movement than normal:

decreased ROM

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Please describe additional contributing factors of disability: *(continued)*

Swelling:

Further admits to mild swelling daily by the end of the day.

Please describe additional contributing factors of disability: *(continued)*

Swelling:

Further admits to mild swelling daily by the end of the day.

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Please describe additional contributing factors of disability: *(continued)*

Disturbance of Locomotion:

Aggravating factors includes sitting >60 min, kneeling, walking >7-10min, stairs.

Interference with Sitting:

Aggravating factors includes sitting >60 min, kneeling, walking >7-10min, stairs.

Please describe additional contributing factors of disability: *(continued)*

Disturbance of Locomotion:

Aggravating factors includes sitting >60 min, kneeling, walking >7-10min, stairs.

Interference with Sitting:

Aggravating factors includes sitting >60 min, kneeling, walking >7-10min, stairs.

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SECTION IV - MUSCLE ATROPHY

RIGHT KNEE	LEFT KNEE
4A. DOES THE VETERAN HAVE MUSCLE ATROPHY? ☐ YES ☒ NO	4A. DOES THE VETERAN HAVE MUSCLE ATROPHY? ☐ YES ☒ NO
4B. IF "YES," IS THE MUSCLE ATROPHY DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION? ☐ YES ☐ NO If "NO," provide rationale:	4B. IF "YES," IS THE MUSCLE ATROPHY DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION? ☐ YES ☐ NO If "NO," provide rationale:
4C. FOR ANY MUSCLE ATROPHY DUE TO A DIAGNOSIS LISTED IN SECTION I, INDICATE SPECIFIC LOCATION OF ATROPHY, PROVIDING MEASUREMENTS IN CENTIMETERS OF NORMAL SIDE AND CORRESPONDING ATROPHIED SIDE, MEASURED AT MAXIMUM MUSCLE BULK. ☐ Right lower extremity (specify location of measurement such as "10cm above or below the knee"): Circumference of more normal side: _____ cm Circumference of atrophied side: _____ cm	4C. FOR ANY MUSCLE ATROPHY DUE TO A DIAGNOSIS LISTED IN SECTION I, INDICATE SPECIFIC LOCATION OF ATROPHY, PROVIDING MEASUREMENTS IN CENTIMETERS OF NORMAL SIDE AND CORRESPONDING ATROPHIED SIDE, MEASURED AT MAXIMUM MUSCLE BULK. ☐ Left lower extremity (specify location of measurement such as "10cm above or below the knee"): Circumference of more normal side: _____ cm Circumference of atrophied side: _____ cm

SECTION V - ANKYLOSIS

NOTE: Ankylosis is the immobilization of a joint due to disease, injury, or surgical procedure.

RIGHT KNEE	LEFT KNEE
5A. IS THERE ANKYLOSIS OF THE KNEE AND/OR LOWER LEG? ☐ YES ☒ NO If "YES," indicate the severity of ankylosis: ☐ Favorable angle in full extension or in slight flexion between 0 and 10 degrees ☐ In flexion between 10 and 20 degrees ☐ In flexion between 20 and 45 degrees ☐ Extremely unfavorable, in flexion at an angle of 45 degrees or more	5A. IS THERE ANKYLOSIS OF THE KNEE AND/OR LOWER LEG? ☐ YES ☒ NO If "YES," indicate the severity of ankylosis: ☐ Favorable angle in full extension or in slight flexion between 0 and 10 degrees ☐ In flexion between 10 and 20 degrees ☐ In flexion between 20 and 45 degrees ☐ Extremely unfavorable, in flexion at an angle of 45 degrees or more
5B. INDICATE ANGLE OF ANKYLOSIS IN DEGREES. _____ degrees ☒ N/A no ankylosis of knee joint	5B. INDICATE ANGLE OF ANKYLOSIS IN DEGREES. _____ degrees ☒ N/A no ankylosis of knee joint
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)? ☐ YES ☐ NO If "YES," complete the Muscle Injuries questionnaire.	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)? ☐ YES ☐ NO If "YES," complete the Muscle Injuries questionnaire.

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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).

RIGHT KNEE	LEFT KNEE
6A. IS THERE RECURRENT SUBLUXATION OR PERSISTENT INSTABILITY? ☐ YES ☒ NO	6A. IS THERE RECURRENT SUBLUXATION OR PERSISTENT INSTABILITY? ☐ YES ☒ NO
6B. IS THERE OR HAS THERE BEEN A LIGAMENT TEAR (SPRAIN)? ☐ YES ☒ NO If "YES," select one of the following. ☐ Complete ligament tear ☐ Incomplete/partial ligament tear	6B. IS THERE OR HAS THERE BEEN A LIGAMENT TEAR (SPRAIN)? ☐ YES ☒ NO If "YES," select one of the following. ☐ Complete ligament tear ☐ Incomplete/partial ligament tear
6C. WAS THE LIGAMENT TEAR REPAIRED? ☐ YES ☐ NO If "YES," select one of the following. ☐ Complete tear repair- successful ☐ Complete tear repair- failed	6C. WAS THE LIGAMENT TEAR REPAIRED? ☐ YES ☐ NO If "YES," select one of the following. ☐ Complete tear repair- successful ☐ Complete tear repair- failed
6D. DOES THE VETERAN REQUIRE A PRESCRIPTION (BY A MEDICAL PROVIDER) OF ANY OF THE FOLLOWING FOR AMBULATION? ☐ YES ☐ NO If "YES," check all that apply. ☐ Cane(s) ☐ Crutches ☐ Walker ☐ Brace(s)	6D. DOES THE VETERAN REQUIRE A PRESCRIPTION (BY A MEDICAL PROVIDER) OF ANY OF THE FOLLOWING FOR AMBULATION? ☐ YES ☐ NO If "YES," check all that apply. ☐ Cane(s) ☐ Crutches ☐ Walker ☐ Brace(s)
6E. IS THERE RECURRENT PATELLAR INSTABILITY? ☐ YES ☒ NO	6E. IS THERE RECURRENT PATELLAR INSTABILITY? ☐ YES ☒ NO
6F. HAS THE VETERAN HAD SURGICAL REPAIR OF THE KNEE FOR PATELLAR INSTABILITY? ☐ YES ☐ NO If "YES," please describe:	6F. HAS THE VETERAN HAD SURGICAL REPAIR OF THE KNEE FOR PATELLAR INSTABILITY? ☐ YES ☐ NO If "YES," please describe:
6G. DOES THE VETERAN REQUIRE A PRESCRIPTION (BY A MEDICAL PROVIDER) OF ANY OF THE FOLLOWING FOR AMBULATION WITH PATELLAR INSTABILITY? ☐ YES ☐ NO If "YES," check all that apply. ☐ Cane(s) ☐ Crutches ☐ Walker ☐ Brace(s)	6G. DOES THE VETERAN REQUIRE A PRESCRIPTION (BY A MEDICAL PROVIDER) OF ANY OF THE FOLLOWING FOR AMBULATION WITH PATELLAR INSTABILITY? ☐ YES ☐ NO If "YES," check all that apply. ☐ Cane(s) ☐ Crutches ☐ Walker ☐ Brace(s)

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SECTION VII - TIBIAL OR FIBULAR IMPAIRMENT

RIGHT KNEE

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?

☐ YES ☒ NO

(If "YES," indicate condition and complete the appropriate sections below):

☐ Stress fracture of the lower leg (If this affects ROM of the ankle, please complete the appropriate musculoskeletal questionnaire and ROM section)

Describe current symptoms:

☐ Acquired and/or traumatic genu recurvatum with objectively demonstrated weakness and insecurity in weight-bearing.

☐ Recurrent patellar dislocation

☐ "Shin Splints" (medial tibial stress syndrome - MTSS) (indicate all treatment and symptoms below)

- ☐ treatment for less than 12 consecutive months
- ☐ unresponsive to shoe orthotics or other conservative treatment
- ☐ requiring treatment for 12 consecutive months or more
- ☐ responsive to surgery
- ☐ unresponsive to surgery

☐ Leg length discrepancy (shortening of any bones of the lower extremity) (If checked, provide length of each lower extremity in inches (to the nearest 1/4 inch) or centimeters measuring from the anterior superior iliac spine to the internal malleolus of the tibia).

Measurements:

Right leg: _____ ☐ cm ☐ inch

For any leg length discrepancy, please describe the relationship to the conditions listed in the diagnosis section above:

LEFT KNEE

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?

☐ YES ☒ NO

(If "YES," indicate condition and complete the appropriate sections below):

☐ Stress fracture of the lower leg (If this affects ROM of the ankle, please complete the appropriate musculoskeletal questionnaire and ROM section)

Describe current symptoms:

☐ Acquired and/or traumatic genu recurvatum with objectively demonstrated weakness and insecurity in weight-bearing.

☐ Recurrent patellar dislocation

☐ "Shin Splints" (medial tibial stress syndrome - MTSS) (indicate all treatment and symptoms below)

- ☐ treatment for less than 12 consecutive months
- ☐ unresponsive to shoe orthotics or other conservative treatment
- ☐ requiring treatment for 12 consecutive months or more
- ☐ responsive to surgery
- ☐ unresponsive to surgery

☐ Leg length discrepancy (shortening of any bones of the lower extremity) (If checked, provide length of each lower extremity in inches (to the nearest 1/4 inch) or centimeters measuring from the anterior superior iliac spine to the internal malleolus of the tibia).

Measurements:

Left leg: _____ ☐ cm ☐ inch

For any leg length discrepancy, please describe the relationship to the conditions listed in the diagnosis section above:

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SECTION VIII - MENISCAL CONDITIONS

RIGHT KNEE	LEFT KNEE
8A. DOES THE VETERAN CURRENTLY HAVE OR HAS THE VETERAN BEEN DIAGNOSED WITH A MENISCUS (SEMILUNAR CARTILAGE) CONDITION? ☐ YES ☒ NO (If "YES," indicate severity and frequency of symptoms): ☐ No current symptoms ☐ Meniscal dislocation ☐ Meniscal tear ☐ Frequent episodes of joint "locking" ☐ Frequent episodes of joint pain ☐ Frequent episodes of joint effusion For all checked boxes above, describe:	8A. DOES THE VETERAN CURRENTLY HAVE OR HAS THE VETERAN BEEN DIAGNOSED WITH A MENISCUS (SEMILUNAR CARTILAGE) CONDITION? ☐ YES ☒ NO (If "YES," indicate severity and frequency of symptoms): ☐ No current symptoms ☐ Meniscal dislocation ☐ Meniscal tear ☐ Frequent episodes of joint "locking" ☐ Frequent episodes of joint pain ☐ Frequent episodes of joint effusion For all checked boxes above, describe:

SECTION IX - SURGICAL PROCEDURES

RIGHT KNEE	LEFT KNEE
9A. INDICATE ANY SURGICAL PROCEDURES THAT THE VETERAN HAS HAD PERFORMED AND PROVIDE THE ADDITIONAL INFORMATION AS REQUESTED (CHECK ALL THAT APPLY): ☒ No surgery ☐ Knee joint resurfacing Date of surgery: ☐ Total knee joint replacement Date of surgery: Total knee joint replacement residuals: ☐ None ☐ Intermediate degrees of residual weakness, pain, or limitation of motion ☐ Chronic residuals consisting of severe painful motion or weakness ☐ Other residuals, describe:	9A. INDICATE ANY SURGICAL PROCEDURES THAT THE VETERAN HAS HAD PERFORMED AND PROVIDE THE ADDITIONAL INFORMATION AS REQUESTED (CHECK ALL THAT APPLY): ☒ No surgery ☐ Knee joint resurfacing Date of surgery: ☐ Total knee joint replacement Date of surgery: Total knee joint replacement residuals: ☐ None ☐ Intermediate degrees of residual weakness, pain, or limitation of motion ☐ Chronic residuals consisting of severe painful motion or weakness ☐ Other residuals, describe:

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☐ Meniscectomy

Date of surgery:

☐ Arthroscopic ligament repair

Date of surgery:

☐ Other surgery not described (specify below):

Date of surgery:

Type of surgery:

☐ Residual signs of symptoms due to meniscectomy, arthroscopic ligament repair or other knee surgery not described above:

Describe residuals:

☐ Meniscectomy

Date of surgery:

☐ Arthroscopic ligament repair

Date of surgery:

☐ Other surgery not described (specify below):

Date of surgery:

Type of surgery:

☐ Residual signs of symptoms due to meniscectomy, arthroscopic ligament repair or other knee surgery not described above:

Describe residuals:

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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 assistive devices used *(check all that apply and indicate frequency):*

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☒ Brace	Frequency of use:	☒ Occasional	☐ Regular	☐ Constant
☐ Crutches	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other, describe:	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

11B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION, INDICATE THE SIDE, AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION.

Brace: Condition: patellofemoral pain syndrome
Side device is used on: Left Side of condition requiring device: Left

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

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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):

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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:

Current OR if retired/unemployed, previous occupation:
defense contractor
0-1 week work time lost in last 12 months
Veteran denies taking any days off due to his knee pain, but will take breaks as needed during work. Describes his bilateral knee pain as an achy 6-7/10 pain underneath his patella with increase in intensity to 10/10 when aggravated. Aggravating factors includes sitting >60 min, kneeling, walking >7-10min, stairs. Further admits to mild swelling daily by the end of the day.

SECTION XV - REMARKS

15A. REMARKS (IF ANY – PLEASE IDENTIFY THE SECTION TO WHICH THE REMARK PERTAINS WHEN APPROPRIATE).

Passive ROM of right knee not performed.
Passive range of motion testing is medically contraindicated as it may cause the Veteran severe pain or the risk of further injury. It is not medically advisable to conduct passive range of motion testing because:
Passive ROM not performed due to potential to cause pain to veteran.

Passive ROM of left knee not performed.
Passive range of motion testing is medically contraindicated as it may cause the Veteran severe pain or the risk of further injury. It is not medically advisable to conduct passive range of motion testing because:
Passive ROM not performed due to potential to cause pain to veteran.

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REMARKS (*cont.*):

Joint Stability:
Right Side:
Is there a history of recurrent subluxation of the right knee? None
Is there a diagnosis of recurrent patellar dislocation of the right knee? None
Is there a history of lateral instability of the right knee? None
Was joint stability testing performed for the right knee? Yes

If joint stability testing was performed is there joint instability? No
Anterior instability (Lachman test): Normal
Posterior instability (Posterior drawer test): Normal
Medial instability (Apply valgus pressure to knee in extension and with 30 degrees of flexion): Normal
Lateral instability (Apply varus pressure to knee in extension and with 30 degrees of flexion): Normal
Left Side:
Is there a history of recurrent subluxation of the left knee? None
Is there a diagnosis of recurrent patellar dislocation of the left knee? None
Is there a history of lateral instability of the left knee? None
Was joint stability testing performed for the left knee? Yes

If joint stability testing was performed is there joint instability? No
Anterior instability (Lachman test): Normal
Posterior instability (Posterior drawer test): Normal
Medial instability (Apply valgus pressure to knee in extension and with 30 degrees of flexion): Normal
Lateral instability (Apply varus pressure to knee in extension and with 30 degrees of flexion): Normal

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REMARKS (*cont.*):

Chronic Exertional Compartment Syndrome
Right Side:
Does the Veteran now have or have they ever had chronic exertional compartment syndrome of the lower extremities? No

Left Side:
Does the Veteran now have or have they ever had chronic exertional compartment syndrome of the lower extremities? No

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REMARKS (*cont.*):

Is there a need for the Veteran/Service Member to follow up with his or her primary care provider regarding any life threatening or abnormal findings in this examination (not limited to claimed condition(s))? No

Reason x-rays not needed or not performed:
X-rays on the day of exam were not clinically indicated

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REMARKS (*cont.*):

Section III: A goniometer was used to measure ROM.
Clarification: discrepancy noted during ROM evaluation. Veteran unable to fully straighten knee bilaterally with goniometer, however was able to walk and straighten knee fully while resting on back on exam table during other evaluations. Thus, extension of 0 rendered bilaterally.

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REMARKS (*cont.*):

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REMARKS (*cont.*):

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REMARKS (*cont.*):

Is the Veteran homeless? No

Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS

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:	16C. DATE SIGNED:
PA-C	Christine Ward Physician Assistant – General Practice	12/13/2023

16D. EXAMINER'S PHONE AND FAX NUMBER:	16E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER:	16F. MEDICAL LICENSE NUMBER AND STATE:
910-238-4443 910-333-0203	1730111824	0010-09863, NC

16G. EXAMINER'S ADDRESS:
34 Office Park Drive Suite 200 Jacksonville NC 28546

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IMPORTANT – THE DEPARTMENT OF VETERAN'S AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN:	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER:	EXAMINATION DATE:
Anthony Robert	*xxxxx*	12/13/2023

Note to examiner **-** The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

Is this questionnaire being completed in conjunction with VA 21-2507, C&P examination request?

☒ Yes ☐ No

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

☒ In-person examination

☒ Records reviewed

☐ Examination via approved video telehealth

☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

Indicate the method used to obtain medical information to complete this document:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

Evidence Reviewed (check all that apply):

☐ No records were reviewed

☐ Not requested

☐ VA claims file (hard copy paper C-file)

☒ VA e-folder

☐ VA electronic health record

☐ Other, please identify other evidence reviewed:

Evidence Comments:

Pg 144: entrance exam 6/1998. No medical conditions noted. BP 126/75
Pg 151: separation exam ?4/2002 reviewed. No medical conditions noted. BP 127/79
Pg 153: separation DD2807 4/2002 reviewed. Silent for back pain, positive for knee trouble, positive for hay fever/sinusitis, positive for asthma. Notes patellofemoral syndrome for knee condition.
Pg 111: PCP note 2/2000 s/p MVA. Diagnosed with paraspinal strain secondary to MVA. Notes cervical and thoracic muscle spasms. No lumbar symptoms noted.
Pg 128: PCP note 5/1999 s/p MVA. Diagnosed with lower lumbar strain secondary to low speed MVA. R knee contusion.
Pg 537: PCP note 8/2003. Notes neck and knee pain on exam. No diagnosis rendered
Pg 799: PCP note 2/2022 with diagnosis of hypertension and bilateral knee pain (previously diagnosis patellofemoral syndrome)

SECTION I - DEFINITIONS

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

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

SECTION II - RESTATEMENT OF REQUESTED OPINION

2a. Insert requested opinion from general remarks:
Does the Veteran have a diagnosis of Bilateral knee condition to include patellofemoral pain syndrome that is at least as likely as not (likelihood is at

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least approximately balanced or nearly equal, if not higher) incurred in or caused by (the) Bilateral knee condition to include patellofemoral pain syndrome during service?

2b. Indicate type of exam for which opinion has been requested *(e.g. Skin Diseases)*:
DBQ MUSC Knee & Lower Leg

SECTION III – MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

Choose the statement that most closely approximates the etiology of this claimed condition.

☒ 3a. The claimed condition was at least as likely as not *(likelihood is at least approximately balanced or nearly equal, if not higher)* incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section C.

☐ 3b. The claimed condition was less likely than not *(likelihood is less than approximately balanced or nearly equal)* incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section C.

3c. Rationale:
Dates of Service:
03/25/98-05/16/02
Claimed Condition:
bilateral knee condition to include patellofemoral pain syndrome
Current Diagnosis:
patellofemoral pain syndrome
In-service Injury, Event or Illness:
service
Veteran had no issues related to the claimed bilateral knee condition to include patellofemoral pain syndrome prior to military service. Current diagnosis of patellofemoral pain syndrome is related to the active duty service. There is evidence of chronicity and a nexus has been established. The veteran was diagnosed with patellofemoral pain syndrome prior to separating from active duty service as noted on separation DD2807 on 4/2002. The veteran continued to be evaluated for bilateral knee pain since separation and continues with diagnosis of patellofemoral pain syndrome today.

SECTION IV – MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

☐ 4a. The claimed condition is at least as likely as not *(likelihood is at least approximately balanced or nearly equal, if not higher)* proximately due to or the result of the Veteran's service connected condition. Provide rationale in section C.

☐ 4b. The claimed condition is less likely than not *(likelihood is less than approximately balanced or nearly equal)* proximately due to or the result of Veteran's service connected condition. Provide rationale in section C.

4c. Rationale:

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

☐ 5a. The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section C.

☐ 5b. The claimed condition, which clearly and unmistakably existed prior to service, was clearly and unmistakably not aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section C.

5c. Rationale:

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

6a. Can you determine a baseline level of severity of *(claimed condition/diagnosis)* based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by *(service connected condition)*?

☐ Yes ☐ No

If "YES" to question 6a, answer the following:

i. Describe the baseline level of severity of *(claimed condition/diagnosis)* based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by *(service connected condition)*:

ii. Provide the date and nature of the medical evidence used to provide the baseline:

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iii. Is The current severity of the *(claimed condition/diagnosis)* greater than the baseline?

☐ Yes ☐ No

If YES, was the Veteran's *(claimed condition/diagnosis)* at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?

☐ Yes ☐ No *(provide rationale in section 6B.)*

If "NO" to question 6a, answer the following:

i. Provide rationale as to why a baseline cannot be established *(e.g. medical evidence is not sufficient to support a determination of a baseline level of severity)*:

ii. Regardless of an established baseline, was the Veteran's *(claimed condition/diagnosis)* at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?

☐ Yes ☐ No *(provide rationale in section 6B.)*

6b. Provide rationale:

SECTION VII - MEDICAL OPINION FOR TOXIC EXPOSURE RISK ACTIVITIES

Choose the statement that most closely approximates the etiology of this claimed condition.

☐ 7a. The claimed condition was at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) caused by the indicated toxic exposure risk activity(ies), after considering the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran. Provide rationale in section C.

☐ 7b. The claimed condition was less likely than not (likelihood is less than approximately balanced or nearly equal) caused by the indicated toxic exposure risk activity(ies), after considering the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran. Provide rationale in section C.

7c. Provide rationale:

SECTION VIII - OPINION REGARDING CONFLICTING MEDICAL EVIDENCE

8. I have reviewed the conflicting medical evidence and am providing the following opinion:

Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION IX – PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9a. PHYSICIAN'S SIGNATURE	9b. PHYSICIAN'S PRINTED NAME	9c. DATE SIGNED
PA-C	Christine Ward Physician Assistant – General Practice	12/13/2023

9d. PHYSICIAN'S PHONE/FAX NUMBERS	9e. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	9f. PHYSICIAN'S ADDRESS
910-238-4443 910-333-0203	1730111824 Lic. #: 0010-09863, NC	34 Office Park Drive Suite 200 Jacksonville NC 28546

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IMPORTANT – THE DEPARTMENT OF VETERAN'S AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN:	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER:	EXAMINATION DATE:
Anthony Robert	*xxxxx*	12/13/2023

Note to examiner **-** The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

Is this questionnaire being completed in conjunction with VA 21-2507, C&P examination request?

☒ Yes ☐ No

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

☒ In-person examination

☒ Records reviewed

☐ Examination via approved video telehealth

☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

Indicate the method used to obtain medical information to complete this document:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

Evidence Reviewed (check all that apply):

☐ No records were reviewed

☐ Not requested

☐ VA claims file (hard copy paper C-file)

☒ VA e-folder

☐ VA electronic health record

☐ Other, please identify other evidence reviewed:

Evidence Comments:

Pg 144: entrance exam 6/1998. No medical conditions noted. BP 126/75
Pg 151: separation exam ?4/2002 reviewed. No medical conditions noted. BP 127/79
Pg 153: separation DD2807 4/2002 reviewed. Silent for back pain, positive for knee trouble, positive for hay fever/sinusitis, positive for asthma. Notes patellofemoral syndrome for knee condition.
Pg 6: Gen Med exam 8/2002 reviewed. Diagnosis of left inguinal hernia repair with residual pain, allergic rhinitis, and asthma/reactive airway disease.
Pg 746: sleep medicine consult note 8/2018. Noted PMH of hypertension. Diagnosis of sleep apnea with AHI of 32 per WatchPat. Further noted diagnosis of overweight/mild obesity and hypertension. Noted family history of sleep apnea including father and paternal uncle.
Pg 494: research study note 7/2018. States "subject returned today with watchPat device with AHI 32.5. will proceed to the next screening for physical and blood test"

SECTION I - DEFINITIONS

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

SECTION II - RESTATEMENT OF REQUESTED OPINION

2a. Insert requested opinion from general remarks:
Is the Veteran's Sleep apnea at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or the

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result of: asthma?

2b. Indicate type of exam for which opinion has been requested *(e.g. Skin Diseases)*:
DBQ RESP Sleep Apnea

SECTION III – MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

Choose the statement that most closely approximates the etiology of this claimed condition.

☐ 3a. The claimed condition was at least as likely as not *(likelihood is at least approximately balanced or nearly equal, if not higher)* incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section C.

☒ 3b. The claimed condition was less likely than not *(likelihood is less than approximately balanced or nearly equal)* incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section C.

3c. Rationale:
Veteran has claimed sleep apnea as being directly related to military service. Based on review of the available evidence, it is less likely than not that the claimed condition is due to service as there is a lack of substantiating evidence supporting a nexus between the current diagnosis of obstructive sleep apnea and military service. Without chronicity during service or after service, a post-service event, illness, or injury is considered to be a more likely etiology.
Furthermore, separation exam in 2002 silent for sleep apnea condition. A nexus has not been established.

Of note, the listed opinion above asks for a secondary opinion in relation to service connected condition of asthma. For claim of sleep apnea, it is less likely than not due to veteran's service connected condition of asthma. After extensive literature review there appear to be some associations between the two conditions, but no causations at this time. Furthermore, per UpToDate the risk factors for developing sleep apnea include older age, male sex, obesity, craniofacial abnormalities, smoking, family history, and nasal congestion. The veteran has multiple of these risk factors that could contribute to his sleep apnea including but not limited to male sex, obesity, family history and nasal congestion. Therefore, for claim of sleep apnea it is less likely than not due to veteran's service connected condition of asthma. A nexus has not been established.
recommend formal secondary opinion for documentation purposes

SECTION IV – MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

☐ 4a. The claimed condition is at least as likely as not *(likelihood is at least approximately balanced or nearly equal, if not higher)* proximately due to or the result of the Veteran's service connected condition. Provide rationale in section C.

☐ 4b. The claimed condition is less likely than not *(likelihood is less than approximately balanced or nearly equal)* proximately due to or the result of Veteran's service connected condition. Provide rationale in section C.

4c. Rationale:

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

☐ 5a. The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section C.

☐ 5b. The claimed condition, which clearly and unmistakably existed prior to service, was clearly and unmistakably not aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section C.

5c. Rationale:

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

6a. Can you determine a baseline level of severity of *(claimed condition/diagnosis)* based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by *(service connected condition)*?

☐ Yes ☐ No

If "YES" to question 6a, answer the following:

i. Describe the baseline level of severity of *(claimed condition/diagnosis)* based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by *(service connected condition)*:

ii. Provide the date and nature of the medical evidence used to provide the baseline:

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iii. Is The current severity of the *(claimed condition/diagnosis)* greater than the baseline?

☐ Yes ☐ No

If YES, was the Veteran's *(claimed condition/diagnosis)* at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?

☐ Yes ☐ No *(provide rationale in section 6B.)*

If "NO" to question 6a, answer the following:

i. Provide rationale as to why a baseline cannot be established *(e.g. medical evidence is not sufficient to support a determination of a baseline level of severity)*:

ii. Regardless of an established baseline, was the Veteran's *(claimed condition/diagnosis)* at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?

☐ Yes ☐ No *(provide rationale in section 6B.)*

6b. Provide rationale:

SECTION VII - MEDICAL OPINION FOR TOXIC EXPOSURE RISK ACTIVITIES

Choose the statement that most closely approximates the etiology of this claimed condition.

☐ 7a. The claimed condition was at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) caused by the indicated toxic exposure risk activity(ies), after considering the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran. Provide rationale in section C.

☐ 7b. The claimed condition was less likely than not (likelihood is less than approximately balanced or nearly equal) caused by the indicated toxic exposure risk activity(ies), after considering the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran. Provide rationale in section C.

7c. Provide rationale:

SECTION VIII - OPINION REGARDING CONFLICTING MEDICAL EVIDENCE

8. I have reviewed the conflicting medical evidence and am providing the following opinion:

Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION IX – PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9a. PHYSICIAN'S SIGNATURE	9b. PHYSICIAN'S PRINTED NAME	9c. DATE SIGNED
PA-C	Christine Ward Physician Assistant – General Practice	12/13/2023

9d. PHYSICIAN'S PHONE/FAX NUMBERS	9e. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	9f. PHYSICIAN'S ADDRESS
910-238-4443 910-333-0203	1730111824 Lic. #: 0010-09863, NC	34 Office Park Drive Suite 200 Jacksonville NC 28546

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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. Please read the privacy act and respondent burden information before completing this form.

NAME OF PATIENT/VETERAN:	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER:	EXAMINATION DATE:
Anthony Robert	*xxxxx*	12/13/2023

NOTE TO PHYSICIAN: Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA21-2507, C&P EXAMINATION REQUEST?

☒ Yes ☐ No

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

☒ In-person examination

☒ Records reviewed

☐ Examination via approved video telehealth

☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

EVIDENCE REVIEWED *(check all that apply):*

☐ Not requested ☐ No records were reviewed

☐ VA claims file (hard copy paper C-file)

☒ VA e-folder (VBMS or Virtual VA)

☐ CPRS

☐ Other (please identify other evidence reviewed):

Evidence Comments:

SECTION I - DIAGNOSIS

NOTE: The diagnosis of sleep apnea must be confirmed by a sleep study; provide sleep study results in Diagnostic testing section. If other respiratory condition is diagnosed, complete the Respiratory and/or Narcolepsy Questionnaire(s), in lieu of this one.

1A. DOES THE VETERAN HAVE OR HAS HE OR SHE EVER HAD SLEEP APNEA?

☒ Yes ☐ No

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO SLEEP APNEA AND CHECK DIAGNOSTIC TYPE:

Diagnosis:	ICD Code:	Date of diagnosis:
☒ Obstructive	G47.33	8/2018
☐ Central		
☐ Mixed, components of both		
☐ Other sleep disorder, specify:		

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO A DIAGNOSIS OF SLEEP APNEA, LIST USING ABOVE FORMAT:

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SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S SLEEP DISORDER CONDITION (brief summary):

Date of Onset:
~ 2002

Details of Onset:
Veteran states his wife would notice episodes of "gasping for air" and excessive snoring.

Course since Onset:
Veteran states his symptoms worsened to the point his wife wouldn't sleep in the same room with him. Continued with snoring, apneic episodes, and excessive daytime tiredness. He was evaluated by a sleep study in 2018 and diagnosed with sleep apnea. He currently uses a CPAP with some relief of symptoms.

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF A SLEEP DISORDER CONDITION?

☐ Yes ☒ No

If "YES," list only those medications required for the Veteran's sleep disorder condition:

2C. DOES THE VETERAN REQUIRE THE USE OF A BREATHING ASSISTANCE DEVICE SUCH AS A CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) MACHINE?

☒ Yes ☐ No

SECTION III - FINDINGS, SIGNS AND SYMPTOMS

3. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO SLEEP APNEA?

☒ Yes ☐ No

(If "YES," check all that apply):

☒ Persistent daytime hypersomnolence

☐ Carbon dioxide retention

☐ Chronic respiratory failure

☐ Cor pulmonale

☐ Requires tracheostomy

☒ Other, describe:

snoring, apneic episodes

SECTION IV - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

4A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ Yes ☒ No

If "YES," describe (brief summary):

4B. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ Yes ☒ No

If YES, are any of these scars painful or unstable; have a total area equal to or greater than 39 square cm (6 square inches); or are located on the head, face or neck?

☐ Yes ☐ No

If YES, also complete VA Form 21-0960f-1, Scars/Disfigurement.

If NO, provide location and measurements of scar in centimeters.

Location:

Measurements:

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Length: cm x width: cm

NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

4C. COMMENTS, IF ANY:

SECTION V - DIAGNOSTIC TESTING

NOTE: If diagnostic test results are in the medical record and reflect the Veteran's current sleep apnea condition, repeat testing is not required.

5A. HAS A SLEEP STUDY BEEN PERFORMED?

☒ Yes ☐ No

If "YES," does the Veteran have documented sleep disorder breathing?

☒ Yes ☐ No

Date of sleep study:

8/2018

Name of facility where sleep study performed, if known:

VA sleep clinic via watchPat device

Results:

sleep apnea, AHI = 32 per hour by watchPat

5B. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ Yes ☒ No

(IF "YES," provide type of test or procedure, date and results in a brief summary):

SECTION VI - FUNCTIONAL IMPACT

6. DOES THE VETERAN'S SLEEP APNEA IMPACT ON HIS OR HER ABILITY TO WORK?

☐ Yes ☒ No

(IF "YES," describe the impact of the Veteran's sleep apnea, providing one or more examples):

SECTION VII - REMARKS

7. REMARKS (if any)

Is there a need for the Veteran/Service Member to follow up with his or her primary care provider regarding any life threatening or abnormal findings in this examination (not limited to claimed condition(s))? No

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Is the Veteran homeless? No

Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION VIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

8A. PHYSICIAN'S SIGNATURE:	8B. PHYSICIAN'S PRINTED NAME:	8C. DATE SIGNED:
PA-C	Christine Ward Physician Assistant – General Practice	12/13/2023
8D. PHYSICIAN'S PHONE AND FAX NUMBER: 910-238-4443 910-333-0203	8E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER: 1730111824	8F. MEDICAL LICENSE NUMBER AND STATE: 0010-09863, NC

8G. PHYSICIAN'S ADDRESS:

34 Office Park Drive Suite 200 Jacksonville NC 28546

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SINUSITIS/RHINITIS AND OTHER CONDITIONS OF THE NOSE, THROAT, LARYNX AND PHARYNX DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT: The Department of Veterans Affairs (VA) will not pay or reimburse any expenses or cost incurred in the process of completing and/or submitting this form. Please read the privacy act and respondent burden information before completing form.

NAME OF PATIENT/VETERAN:	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER:	EXAMINATION DATE:
Anthony Robert	*xxxxx*	12/13/2023

NOTE TO PHYSICIAN: Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA21-2507, C&P EXAMINATION REQUEST?

☒ Yes ☐ No

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

☒ In-person examination

☒ Records reviewed

☐ Examination via approved video telehealth

☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

EVIDENCE REVIEWED *(check all that apply):*

☐ Not requested ☐ No records were reviewed

☐ VA claims file (hard copy paper C-file)

☒ VA e-folder (VBMS or Virtual VA)

☐ CPRS

☐ Other (please identify other evidence reviewed):

Evidence Comments:

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A SINUS, NOSE, THROAT, LARYNX OR PHARYNX CONDITION? (This is the condition the Veteran is claiming or for which an exam has been requested.)

☒ Yes ☐ No

1B. IF YES, SELECT THE VETERAN'S CONDITION (check all that apply):	ICD Code:	Date of diagnosis:
☐ Chronic Sinusitis		
☒ Allergic Rhinitis	J30.9	SC 2002
☐ Non-Allergic Rhinitis		
☐ Bacterial Rhinitis		
☐ Granulomatous Rhinitis		
☐ Chronic Laryngitis		
☐ Laryngectomy		

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☐ Laryngeal Stenosis		
☐ Aphonia		
☐ Pharyngeal Injury *(describe):*		
☐ Deviated Nasal Septum (Traumatic)		
☐ ANATOMICAL LOSS OF PART OF NOSE *(Complete VA Form 21-0960F-1, Scars/ Disfigurement Disability Benefits Questionnaire in lieu of this questionnaire)*		
☐ Benign or Malignant Neoplasm of Sinus, Nose, Throat, Larynx or Pharynx		
☐ Other *(specify)* Other Diagnosis #1:		
Other Diagnosis #2:		

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO THE SINUSES, NOSE, THROAT, LARYNX, OR PHARYNX CONDITION(S), LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S SINUS, NOSE, THROAT, LARYNX, OR PHARYNX CONDITION:

Onset date:
SC 2002

Details of onset:
Veteran is service connected for allergic rhinitis since 5/2002. This is an increase exam and will focus only on current symptoms along with changes in severity and/or treatment since last DBQ exam performed in 8/2002.

Course since onset:
Veteran states his symptoms have worsened over the years. Continues with nasal congestion to the point of needing nightly nasal spray in order to use CPAP. Further admits to itchy eyes, sneezing, coughing. States he has noted allergies to various grasses/trees.

Current symptoms:
Continues with nasal congestion to the point of needing nightly nasal saline spray in order to use CPAP. Further admits to itchy eyes, sneezing, coughing. States he has noted allergies to various grasses/trees.

Current treatment:
Benadryl prn. Claritin daily.

SECTION III - NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS?

☒ Yes ☐ No

(If "NO," proceed to Section IV) (If "YES," check all that apply):

☐ Sinusitis *(If checked, complete Part A below)*

☒ Rhinitis *(If checked, complete Part B below)*

☐ Larynx or pharynx condition *(If checked, complete Part C below)*

☐ Deviated nasal septum (traumatic) *(If checked, complete Part D below)*

☐ Tumors or neoplasms *(If checked, complete Part E below)*

☐ Other pertinent physical findings or scars due to nose, throat, larynx or pharynx conditions *(If checked, complete Part F below)*

PART A – Sinusitis

A1. INDICATE THE SINUSES/TYPE OF SINUSITIS CURRENTLY AFFECTED BY THE VETERAN'S CHRONIC SINUSITIS (Check all that apply):

☐ None ☐ Maxillary ☐ Frontal ☐ Ethmoid ☐ Sphenoid ☐ Pansinusitis

A2. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO CHRONIC SINUSITIS?

☐ Yes ☐ No

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(If "YES," check all that apply):

☐ Chronic sinusitis detected only by imaging studies (See Diagnostic Testing Section)

☐ Episodes of sinusitis

☐ Near constant sinusitis (If checked, describe frequency):

☐ Headaches

☐ Pain of affected sinus

☐ Tenderness of affected sinus

☐ Purulent discharge

☐ Crusting

☐ Other (describe):

For all checked conditions, describe:

A3. HAS THE VETERAN HAD NON-INCAPACITATING EPISODES OF SINUSITIS CHARACTERIZED BY HEADACHES, PAIN AND PURULENT DISCHARGE OR CRUSTING IN THE PAST 12 MONTHS?

☐ Yes ☐ No

(If "YES," provide the total number of non-incapacitating episodes over the past 12 months):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

A4. HAS THE VETERAN HAD INCAPACITATING EPISODES OF SINUSITIS REQUIRING PROLONGED (4 TO 6 WEEKS) OF ANTIBIOTICS TREATMENT IN THE PAST 12 MONTHS?

NOTE: For VA purposes, an incapacitating episode of sinusitis means one that requires bed rest and treatment prescribed by a physician.

☐ Yes ☐ No

(If "YES," provide the total number of incapacitating episodes of sinusitis requiring prolonged (4 to 6 weeks) of antibiotic treatment over the past 12 months):

☐ 1 ☐ 2 ☐ 3 or more

A5. HAS THE VETERAN HAD SINUS SURGERY?

☐ Yes ☐ No

(If "YES," specify type of surgery):

☐ Radical (open sinus surgery)

☐ Endoscopic

☐ Other:

(Type of procedure, sinuses operated on and side(s)):

(Date(s) of surgery *(if repeated sinus surgery, provide all dates of surgery)*):

A6. IF VETERAN HAS HAD RADICAL SINUS SURGERY, DID CHRONIC OSTEOMYELITIS FOLLOW THE SURGERY?

☐ Yes ☐ No

(If "YES," complete VA Form 21-0960M-11, Osteomyelitis Disability Benefits Questionnaire)

A7. HAS THE VETERAN HAD REPEATED SINUS-RELATED SURGICAL PROCEDURES PERFORMED?

☐ Yes ☐ No

PART B - RHINITIS

B1. IS THERE GREATER THAN 50% OBSTRUCTION OF THE NASAL PASSAGE ON BOTH SIDES DUE TO RHINITIS?

☐ Yes ☒ No

B2. IS THERE COMPLETE OBSTRUCTION ON THE LEFT SIDE DUE TO RHINITIS?

☐ Yes ☒ No

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B3. IS THERE COMPLETE OBSTRUCTION ON THE RIGHT SIDE DUE TO RHINITIS?

☐ Yes ☒ No

B4. IS THERE PERMANENT HYPERTROPHY OF THE NASAL TURBINATES?

☐ Yes ☒ No

B5. ARE THERE NASAL POLYPS?

☐ Yes ☒ No

B6. DOES THE VETERAN HAVE ANY OF THE FOLLOWING GRANULOMATOUS CONDITIONS?

☐ Yes ☒ No

(If "YES," check all that apply)

☐ Granulomatous rhinitis

☐ Rhinoscleroma

☐ Wegener's granulomatosis

☐ Lethal midline granuloma

☐ Other granulomatous infection (Describe):

PART C - LARYNX AND PHARYNX CONDITIONS

C1. DOES THE VETERAN HAVE CHRONIC LARYNGITIS?

☐ Yes ☐ No

(If "YES," does the Veteran have any of the following symptoms due to chronic laryngitis?)

☐ Yes ☐ No

(If "YES," check all that apply)

☐ Hoarseness (If checked, describe frequency):

☐ Inflammation of vocal cords

☐ Inflammation of mucous membrane

☐ Thickening of vocal chords

☐ Nodules of vocal chords

☐ Submucous infiltration of vocal chords

☐ Vocal chord polyps

☐ Other (describe):

C2. HAS THE VETERAN HAD A LARYNGECTOMY?

☐ Yes ☐ No

(If "YES," specify)

☐ Total laryngectomy
☐ Partial laryngectomy

(If checked, does the Veteran have any residuals of the partial laryngectomy?)

☐ Yes ☐ No

(If "YES," describe)

C3. DOES THE VETERAN HAVE LARYNGEAL STENOSIS, INCLUDING RESIDUALS OF LARYNGEAL TRAUMA (unilateral or bilateral)?

☐ Yes ☐ No

(If "YES," assess for upper airway obstruction with pulmonary function testing to include Flow-Volume Loop, and provide results in Diagnostic Testing Section)

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C4. DOES THE VETERAN HAVE COMPLETE ORGANIC APHONIA?

☐ Yes ☐ No

(If "YES," check all that apply)

- ☐ Constant inability to speak above a whisper
- ☐ Constant inability to communicate by speech
- ☐ Other (describe):

C5. DOES THE VETERAN HAVE INCOMPLETE ORGANIC APHONIA?

☐ Yes ☐ No

(If "YES," check all that apply)

- ☐ Hoarseness (If checked, describe frequency):
- ☐ Inflammation of vocal cords
- ☐ Inflammation of mucous membrane
- ☐ Thickening of vocal chords
- ☐ Nodules of vocal chords
- ☐ Submucous infiltration of vocal chords
- ☐ Vocal chord polyps
- ☐ Other (describe):

C6. HAS THE VETERAN HAD A PERMANENT TRACHEOSTOMY?

☐ Yes ☐ No

(If "YES," describe reason for tracheostomy and potential for decannulation):

C7. HAS THE VETERAN HAD AN INJURY TO THE PHARYNX?

☐ Yes ☐ No

(If "YES," check all findings, signs and symptoms that apply):

- ☐ Obstruction of the pharynx
- ☐ Obstruction of the nasopharynx
- ☐ Stricture of the pharynx
- ☐ Stricture of the nasopharynx
- ☐ Absence of the soft palate secondary to trauma
- ☐ Absence of the soft palate secondary to chemical burn
- ☐ Absence of the soft palate secondary to granulomatous disease
- ☐ Paralysis of the soft palate
- ☐ Swallowing difficulty
- ☐ Nasal regurgitation
- ☐ Speech impairment
- ☐ Other (describe):

C8. DOES THE VETERAN HAVE VOCAL CHORD PARALYSIS OR ANY OTHER PHARYNGEAL OR LARYNGEAL CONDITIONS?

☐ Yes ☐ No

(If "YES," describe):

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PART D - DEVIATED NASAL SEPTUM (TRAUMATIC)

D1. IS THERE AT LEAST 50% OBSTRUCTION OF THE NASAL PASSAGE ON BOTH SIDES DUE TO TRAUMATIC SEPTAL DEVIATION?

☐ Yes ☐ No

D2. IS THE VETERAN'S DEVIATED SEPTUM TRAUMATIC?

☐ Yes ☐ No

D3. IS THERE COMPLETE OBSTRUCTION ON LEFT SIDE DUE TO TRAUMATIC SEPTAL DEVIATION?

☐ Yes ☐ No

D4. IS THERE COMPLETE OBSTRUCTION ON RIGHT SIDE DUE TO TRAUMATIC SEPTAL DEVIATION?

☐ Yes ☐ No

PART E - TUMORS AND NEOPLASMS

E1. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION?

☐ Yes ☐ No

(If "YES," complete the following section)

E2. IS THE NEOPLASM:

☐ Benign ☐ Malignant

E3. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

☐ Yes ☐ No; watchful waiting

(If "YES," indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply)):

☐ Treatment completed; currently in watchful waiting status

☐ Surgery (If checked, describe):

(Date(s) of surgery):

☐ Radiation therapy

(Date of most recent treatment):

(Date of completion of treatment or anticipated date of completion):

☐ Antineoplastic chemotherapy

(Date of most recent treatment):

(Date of completion of treatment or anticipated date of completion):

☐ Other therapeutic procedure (If checked, describe procedure):

(Date of most recent procedure):

☐ Other therapeutic treatment (If checked, describe treatment):

(Date of completion of treatment or anticipated date of completion):

E4. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (including metastases) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT ABOVE?

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☐ Yes ☐ No

(If "YES," list residual conditions and complications (brief summary)):

E5. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION, DESCRIBE USING THE ABOVE FORMAT:

PART F - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

F1. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ Yes ☐ No

If "YES," describe (brief summary):

F2. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ Yes ☐ No

If "YES," are any of these scars painful or unstable; have a total area equal to or greater than 39 square cm (6 square inches); or are located on the head, face or neck? (an "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

☐ Yes ☐ No

If "YES," also complete VA Form 21-0960F-1, Scars/Disfigurement.

If "NO," provide location and measurements of scar in centimeters.

Location:

Measurements:

length cm x width cm

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

F3. COMMENTS, IF ANY:

F4. DOES THE VETERAN HAVE LOSS OF PART OF THE NOSE OR OTHER SCARS OF THE NOSE EXPOSING BOTH NASAL PASSAGES?

☐ Yes ☐ No

F5. DOES THE VETERAN HAVE LOSS OF PART OF THE NOSE OR OTHER SCARS CAUSING LOSS OF PART OF ONE ALA?

☐ Yes ☐ No

F6. DOES THE VETERAN HAVE LOSS OF PART OF THE NOSE OR OTHER SCARS CAUSING ANY OTHER DISFIGUREMENT?

☐ Yes ☐ No

SECTION IV - DIAGNOSTIC TESTING

NOTE: If testing has been performed and reflects the Veteran's current condition, repeat testing is not required. Specific diagnostic testing is not required for many conditions, but if performed, record in this section.

4A. HAVE IMAGING STUDIES OF THE SINUSES OR OTHER AREAS BEEN PERFORMED?

☐ Yes ☒ No

(If "YES," check all that apply)

☐ Magnetic resonance imaging (MRI) Date:

Results:

☐ Computed tomography (CT) Date:

Results:

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☐ X-rays: Date:

Results:

☐ Other: Date:

Results:

4B. HAS ENDOSCOPY BEEN PERFORMED?

☐ Yes ☒ No

(If "YES," check all that apply):

☐ Nasal endoscopy Date:

Results:

☐ Laryngeal endoscopy Date:

Results:

☐ Bronchoscopy Date:

Results:

☐ Other endoscopy Date:

Results:

4C. HAS THE VETERAN HAD A BIOPSY OF THE LARYNX OR PHARYNX?

☐ Yes ☒ No

(If "YES," complete the following):

Site of biopsy: Date:

Results: ☐ Benign ☐ Pre-Malignant ☐ Malignant

Describe results:

4D. HAS THE VETERAN HAD PULMONARY FUNCTION TESTING TO ASSESS FOR UPPER AIRWAY OBSTRUCTION DUE TO LARYNGEAL STENOSIS?

☐ Yes ☒ No

If "YES," indicate results:

☐ FEV-1 of 71 to 80% predicted
☐ FEV-1 of 56 to 70% predicted
☐ FEV-1 of 40 to 55% predicted
☐ FEV-1 less than 40% predicted

Is the Flow-Volume Loop compatible with upper airway obstruction?

☐ Yes ☐ No

4E. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ Yes ☒ No

(If "YES," provide type of test or procedure, date and results (brief summary)):

SECTION V - FUNCTIONAL IMPACT AND REMARKS

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5A. DOES THE VETERAN'S SINUS, NOSE, THROAT, LARYNX OR PHARYNX CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ Yes ☒ No

(If "YES," describe impact of each of the Veteran's sinus, nose, throat, larynx or pharynx conditions, providing one or more examples):

5B. REMARKS (if any)

Is there a need for the Veteran/Service Member to follow up with his or her primary care provider regarding any findings in this examination (not limited to claimed condition(s))? No

Of note, during evaluation veteran has >50% obstruction of left nostril and <50% obstruction of right nostril on exam.

Is the Veteran homeless? No

Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION VII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

7A. PHYSICIAN'S SIGNATURE:	7B. PHYSICIAN'S PRINTED NAME:	7C. DATE SIGNED:
PA-C	Christine Ward Physician Assistant – General Practice	12/13/2023
7D. PHYSICIAN'S PHONE AND FAX NUMBERS:	**7E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER:**	**7F. PHYSICIAN'S ADDRESS:**
910-238-4443 910-333-0203	1730111824 0010-09863, NC	34 Office Park Drive Suite 200 Jacksonville NC 28546

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

If questions or issues arise upon review of this Examination, please contact the VA Medical Center or DOD facility that processed the request for examination.
Contractor: Logistics Health Incorporated

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Respondent Burden: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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