



EYE CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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

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

NOTE: This examination must be conducted by a licensed ophthalmologist or by a licensed optometrist. The examiner must identify the disease, injury or other pathologic process responsible for any decrease in visual acuity or other visual impairment found. Examinations of visual fields or muscle function should be conducted ONLY when there is a medical indication of disease or injury that may be associated with visual field defect or impaired muscle function. If indicated to address requested claim, and not medically contraindicated, dilated fundus exam required.

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

Veteran/Claimant

Other: please describe

Empty text box for describing other requestor.

Are you a VA Healthcare provider? Yes No

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

Was the Veteran examined in person? Yes No

If no, how was the examination conducted?

Empty text box for describing examination method.

EVIDENCE REVIEW

Evidence reviewed:

No records were reviewed

Records reviewed

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

Large empty text box for identifying evidence reviewed and date range.

SECTION I - DIAGNOSIS

NOTE: The diagnosis section should be filled out AFTER the clinician has completed the examination.

1A. DOES THE VETERAN CURRENTLY HAVE AN EYE CONDITION (*other than congenital or developmental errors of refraction*)?

YES NO (*If "Yes," provide only diagnoses that pertain to eye conditions:*)

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1B. IF THERE ARE ADDITIONAL OR PRIOR DIAGNOSES THAT PERTAIN TO EYE CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

1. DESCRIBE THE HISTORY (*including onset and course*) OF THE VETERAN'S CURRENT EYE CONDITION(S) (*Brief summary*):

SECTION III - PHYSICAL EXAMINATION

1. VISUAL ACUITY

Visual acuity should be reported according to the lines on the Snellen chart or its equivalent. If assessment of the veteran's visual acuity falls between two lines on the Snellen chart, round up to the higher (worse) level (poorer vision) for answers a-d below. (For example, 20/60 would be reported as 20/70; 20/80 would be reported as 20/100. etc.)

Examination of visual acuity must include central uncorrected and corrected visual acuity for distance and near vision. Evaluate visual acuity on the basis of corrected distance vision with central fixation. Visual acuity should not be determined with eccentric fixation or viewing.

a. Uncorrected distance:

RIGHT: 5/200 or worse 10/200 15/200 20/200 20/100 20/70 20/50 20/40 20/20 or better
LEFT: 5/200 or worse 10/200 15/200 20/200 20/100 20/70 20/50 20/40 20/20 or better

b. Corrected distance:

RIGHT: 5/200 or worse 10/200 15/200 20/200 20/100 20/70 20/50 20/40 20/20 or better
LEFT: 5/200 or worse 10/200 15/200 20/200 20/100 20/70 20/50 20/40 20/20 or better

c. Uncorrected Near (Reading):

RIGHT: 5/200 or worse 10/200 15/200 20/200 20/100 20/70 20/50 20/40 20/20 or better
LEFT: 5/200 or worse 10/200 15/200 20/200 20/100 20/70 20/50 20/40 20/20 or better

d. Corrected Near (Reading):

RIGHT: 5/200 or worse 10/200 15/200 20/200 20/100 20/70 20/50 20/40 20/20 or better
LEFT: 5/200 or worse 10/200 15/200 20/200 20/100 20/70 20/50 20/40 20/20 or better

SECTION III - PHYSICAL EXAMINATION (Continued)

2. DIFFERENCE IN CORRECTED VISUAL ACUITY FOR DISTANCE AND NEAR VISION

a. Does the Veteran have a difference equal to two or more lines on the Snellen test type chart or its equivalent between distance and near corrected vision, with the near vision being worse?

YES NO (If "Yes," complete items 2b through 2d)

b. Provide a second recording of corrected distance and near vision

Second recording of corrected distance vision:

RIGHT: 5/200 or worse 10/200 15/200 20/200 20/100 20/70 20/50 20/40 20/20 or better

LEFT: 5/200 or worse 10/200 15/200 20/200 20/100 20/70 20/50 20/40 20/20 or better

Second recording of corrected near vision:

RIGHT: 5/200 or worse 10/200 15/200 20/200 20/100 20/70 20/50 20/40 20/20 or better

LEFT: 5/200 or worse 10/200 15/200 20/200 20/100 20/70 20/50 20/40 20/20 or better

c. Explain reason for the difference between distance and near corrected vision

d. Does the lens required to correct distance vision in the poorer eye differ by more than 3 diopters from the lens required to correct distance vision in the better eye?

YES NO (If "Yes," explain reason for the difference):

3. PUPILS

a. Pupil diameter: Right: _____ mm Left: _____ mm

b. Pupils are round and reactive to light? YES NO

c. Is an afferent pupillary defect present? YES NO

(If "Yes," indicate affected eye): Right Left Both

d. Other (Describe): _____

Eye affected Right Left Both

4. ANATOMICAL LOSS, LIGHT PERCEPTION ONLY, EXTREMELY POOR VISION OR BLINDNESS

a. Does the Veteran have anatomical loss, light perception only, extremely poor vision or blindness of either eye?

YES NO (If "Yes," complete items 4b through 4f)

b. Does the Veteran have anatomical loss of either eye?

YES NO

If "Yes," indicate affected eye:

Right Left Both

If "Yes," is the Veteran able to wear an ocular prosthesis?

YES NO

If "No," provide reason: _____

c. Is the Veteran's vision limited to no more than light perception only in either eye?

YES NO

If "Yes," indicate for which eye(s) the Veteran's vision is limited to no more than light perception

Right Left Both

d. Is the Veteran able to recognize test letters at 1 foot or closer?

YES NO

If "No," indicate with which eye(s) the Veteran is unable to recognize test letters at 1 foot or closer

Right Left Both

e. Is the Veteran able to perceive objects, hand movements, or count fingers at 3 feet?

YES NO

If "No," indicate with which eye(s) the Veteran is unable to perceive objects, hand movements, or count fingers at 3 feet:

Right Left Both

f. Does the Veteran have visual acuity of 20/200 or less in the better eye with use of a correcting lens based upon visual acuity loss (i.e. USA statutory blindness with bilateral visual acuity of 20/200 or less)?

YES NO

5. ASTIGMATISM

a. Does the Veteran have a corneal irregularity that results in severe irregular astigmatism?

YES NO (If "Yes," complete items 5b and 5c)

b. Does the Veteran customarily wear contact lenses to correct for the above corneal irregularity?

YES NO

If "Yes," does using contact lenses result in more visual improvement than using the standard spectacle correction?

YES NO

c. Was the corrected visual acuity determined using contact lenses?

YES NO

If "No," explain: _____

SECTION III - PHYSICAL EXAMINATION (Continued)

6. DIPLOPIA

a. Does the Veteran have diplopia (*double vision*)? YES NO (*If "Yes," complete items 6b through 6e*)

b. Provide etiology (*such as traumatic injury, thyroid eye disease, myasthenia gravis, etc.*):

NOTE: For VA purposes, examiners must use either a Goldmann perimeter chart or the Tangent Screen method identifying the four major quadrants (upward, downward, left lateral, and right lateral) and the central fields (20 degrees or less).

c. Indicate the areas where diplopia is present (*the fields in which the Veteran sees double using binocular vision*):

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Central 20 degrees | <input type="checkbox"/> 21 to 30 degrees | <input type="checkbox"/> 31 to 40 degrees | <input type="checkbox"/> Greater than 40 degrees |
| | <input type="checkbox"/> Down | <input type="checkbox"/> Down | <input type="checkbox"/> Down |
| | <input type="checkbox"/> Lateral | <input type="checkbox"/> Lateral | <input type="checkbox"/> Lateral |
| | <input type="checkbox"/> Up | <input type="checkbox"/> Up | <input type="checkbox"/> Up |

d. Indicate frequency of the diplopia: Constant Occasional

If occasional, indicate frequency of diplopia and most recent occurrence: _____

e. Is the diplopia correctable with standard spectacle correction? YES NO

If "No," is the diplopia correctable with standard spectacle correction that includes a special prismatic correction? YES NO

7. TONOMETRY

a. If tonometry was performed, provide results:

Right eye pressure: _____ Left eye pressure: _____

b. Tonometry method used:

Goldmann applanation

Other (*Describe*): _____

8. SLIT LAMP AND EXTERNAL EYE EXAM

a. Slit Lamp:

Normal Bilaterally Abnormal (*If Abnormal, complete items 8b through 8g*)

b. External exam/lids/lashes:

Right: Normal Other (*Describe*): _____

Left: Normal Other (*Describe*): _____

c. Conjunctiva/sclera:

Right: Normal Other (*Describe*): _____

Left: Normal Other (*Describe*): _____

d. Cornea:

Right: Normal Other (*Describe*): _____

Left: Normal Other (*Describe*): _____

e. Anterior chamber:

Right: Normal Other (*Describe*): _____

Left: Normal Other (*Describe*): _____

f. Iris:

Right: Normal Other (*Describe*): _____

Left: Normal Other (*Describe*): _____

g. Lens:

Right: Normal Other (*Describe*): _____

Left: Normal Other (*Describe*): _____

9. INTERNAL EYE EXAM (FUNDUS)

a. Fundus:

Normal bilaterally Abnormal (*If Abnormal, complete items 9b through 9f*)

b. Optic disc:

Right: Normal Other (*Describe*): _____

Left: Normal Other (*Describe*): _____

c. Macula:

Right: Normal Other (*Describe*): _____

Left: Normal Other (*Describe*): _____

SECTION III - PHYSICAL EXAMINATION (Continued)

9. INTERNAL EYE EXAM (Continued)

d. Vessels

Right: Normal Other (Describe): _____
 Left: Normal Other (Describe): _____

e. Vitreous

Right: Normal Other (Describe): _____
 Left: Normal Other (Describe): _____

f. Periphery

Right: Normal Other (Describe): _____
 Left: Normal Other (Describe): _____

10. VISUAL FIELDS

a. Does the Veteran have a documented visual field defect?

YES NO (If "Yes," complete items 10b through 10f)

NOTE: For VA purposes, examiners must perform visual field testing using either Goldmann kinetic perimetry or automated perimetry using Humphrey Model 750, Octopus Model 101, or later versions of these perimetric devices with simulated kinetic Goldmann testing capability. The results must be documented for at least 16 meridians 22½-degrees apart for each eye. If additional testing is necessary to evaluate visual fields, it must be conducted using either a tangent screen or a 30-degree threshold visual field with the Goldmann III stimulus size, and the results must be documented on the examination report.

b. Was visual field testing performed? YES NO

Results Using Goldmann's equivalent III/4e target
 Using Goldmann's equivalent IV/4e target (used for aphakic individuals not well adapted to contact lens correction or pseudophakic individuals not well adapted to intraocular lens implant)
 Other (Describe): _____

c. Does the Veteran have contraction of a visual field? YES NO (If "Yes," complete the following chart):

Meridian	Normal Degrees	Right Eye (OD) Actual Degrees (Cannot exceed the normal degrees)	Left Eye (OS) Actual Degrees (Cannot exceed the normal degrees)
Up (90° OD /90° OS)	45		
Up Temporally (45° OD/135° OS)	55		
Temporally (0° OD /180° OS)	85		
Down Temporally (315° OD /225° OS)	85		
Down (270° OD /270° OS)	65		
Down Nasally (225° OD /315° OS)	50		
Nasally (180° OD /0° OS)	60		
Up Nasally (135° OD /45° OS)	55		

d. Does the Veteran have loss of a visual field? YES NO (If "Yes," check all that apply and indicate eye affected)

Homonymous hemianopsia Right Left Both
 Loss of temporal half of visual field Right Left Both
 Loss of nasal half of visual field Right Left Both
 Loss of inferior half of visual field Right Left Both
 Loss of superior half of visual field Right Left Both
 Other (Specify:) _____ Right Left Both

e. Does the Veteran have a scotoma? YES NO (If "Yes," check all that apply and indicate eye affected)

Scotoma affecting at least 1/4 of the visual field Right Left Both
 Centrally located scotoma Right Left Both

f. Does the Veteran have legal (statutory) blindness based upon visual field loss (visual field diameter of 20 degrees or less in the better eye, even if the corrected visual acuity is 20/20)?

YES NO

SECTION IV - EYE CONDITIONS

1. Does the Veteran have any of the following eye conditions?

- YES (If "Yes," check all that apply) NO (If "No," proceed to Section V)
- External Eye Conditions, including the eyelash, eyelid, and eyebrow (Complete item 2 below)
- Lacrimal System Conditions, including Dry Eye Syndrome (Complete item 3 below)
- Cornea/Conjunctiva Conditions (Complete item 4 below)
- Glaucoma (Complete item 5 below)
- Uveal Tract Conditions (Complete item 6 below)
- Lens Conditions, including Cataracts (Complete item 7 below)
- Retina, Macula, or Vitreous Conditions (Complete item 8 below)
- Neuro-Ophthalmic Conditions (Complete item 9 below)
- Ocular Neoplasms (Complete item 10 below)
- Trauma/Hemorrhage (Complete item 11 below)
- Other Eye Conditions (Complete item 12 below)

2. EXTERNAL EYE CONDITION, INCLUDING THE EYELASH, EYELID, AND EYEBROW

a. Indicate the Veteran's condition and side affected (check all that apply):

- | | | | |
|---|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Ectropion | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Entropion | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Lagophthalmos | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Complete loss of eyebrows | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Complete loss of eyelashes | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Partial or complete loss of eyelid | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Pterygium | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Pinguecula | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Symblepharon | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other (Describe): _____ | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

b. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to an external eye condition?

- YES NO There is no decrease in visual acuity or other visual impairment

If "Yes," specify the external eye condition(s) responsible for visual impairment _____

If "No," explain: _____

3. LACRIMAL SYSTEM CONDITIONS, including Dry Eye Syndrome

a. Does the Veteran have a disorder of the lacrimal apparatus, to include epiphora, dacryocystitis, etc.?

- YES NO

If "Yes," specify condition and side affected: _____ Right Left Both

b. Is the Veteran's decrease in visual acuity or other visual impairment attributable to a lacrimal system condition?

- YES NO There is no decrease in visual acuity or other visual impairment

If "Yes," specify the lacrimal system condition(s) responsible for visual impairment: _____

If "No," explain: _____

c. Does the Veteran have dry eye syndrome? YES NO (If "Yes," please complete items 3d through 3h)

d. Indicate the eye affected by dry eye syndrome: Right Left Both

e. Date dry eye syndrome began: _____

f. Has the Veteran ever had elective procedures, such as laser eye surgery (e.g. LASIK)? YES NO

If "Yes," specify which eye, procedure, and date: Right Left Both

Name or description of procedure: _____

Date(s) of procedure: _____

Did dry eye syndrome begin after the elective procedure? YES NO

SECTION IV - EYE CONDITIONS (Continued)

3. LACRIMAL SYSTEM CONDITIONS, including DRY EYE SYNDROME (Continued)

g. Indicate the types of treatment used to treat dry eye syndrome:

- No treatment
- Over-the-counter artificial tear drops
- Prescription medications
- Special contact lenses
- Plugs to block the tear ducts through which tears drain
- Surgical procedures

Name or description of surgical procedure: _____

Date(s) of surgery: _____

Other (Describe): _____

h. Is the Veteran's decrease in visual acuity or other visual impairment attributable to dry eye syndrome?

- YES NO There is no decrease in visual acuity or other visual impairment

If "Yes," specify the dry eye syndrome condition(s) responsible for visual impairment: _____

If "No," explain: _____

4. CORNEA/CONJUNCTIVA CONDITIONS

a. Indicate the Veteran's condition and side affected:

- | | | | |
|--|--------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> Keratopathy | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Trachomatous conjunctivitis
<i>(Indicate if it is active or inactive for each eye)</i> | <input type="checkbox"/> Right | <input type="checkbox"/> Active | <input type="checkbox"/> Inactive |
| | <input type="checkbox"/> Left | <input type="checkbox"/> Active | <input type="checkbox"/> Inactive |
| <input type="checkbox"/> Chronic conjunctivitis (non trachomatous)
<i>(Indicate if it is active or inactive for each eye)</i> | <input type="checkbox"/> Right | <input type="checkbox"/> Active | <input type="checkbox"/> Inactive |
| | <input type="checkbox"/> Left | <input type="checkbox"/> Active | <input type="checkbox"/> Inactive |
| <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Corneal transplant | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other (describe): _____ | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

b. Is the Veteran's decrease in visual acuity or other visual impairment attributable to a corneal condition?

- YES NO There is no decrease in visual acuity or other visual impairment

If "Yes," specify corneal condition(s) responsible for visual impairment: _____

If "No," explain: _____

c. If the Veteran had a corneal transplant, please indicate the current residual(s).

(Check all that apply):

- | | | | |
|---|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> No current residuals | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Photophobia | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Glare sensitivity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, (describe): _____ | | | |

5. GLAUCOMA

a. Specify the type of glaucoma:

- | | | | | |
|--|---------------|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Angle-closure | Eye affected: | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Open-angle | Eye affected: | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, specify type <i>(For example, neovascular, phakolytic, etc.)</i> | Eye affected: | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

SECTION IV - EYE CONDITIONS (Continued)

GLAUCOMA (Continued)

b. Does the glaucoma require continuous medication for treatment? YES NO

If "Yes," list medication(s) used for treatment of glaucoma: _____

c. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to glaucoma?

YES NO There is no decrease in visual acuity or other visual impairment

If "No," explain: _____

6. UVEAL TRACT CONDITIONS

a. Indicate the Veteran's condition and eye affected:

- Choroidopathy (including uveitis, iritis, cyclitis, or choroiditis) Right Left Both
 Scleritis Right Left Both
 Tuberculosis of the eye (indicate if it is active or inactive for each eye) Right Active Inactive
 Left Active Inactive
 Other (Describe): _____ Right Left Both

b. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to an uveal tract eye condition?

YES NO There is no decrease in visual acuity or other visual impairment.

If "Yes," specify uveal tract condition(s) responsible for visual impairment: _____

If "No," explain: _____

7. LENS CONDITIONS, INCLUDING CATARACTS

a. Indicate cataract condition:

- Preoperative (cataract is present) Eye affected: Right Left Both
 Postoperative (cataract has been removed) Eye affected: Right Left Both

Is there a replacement intraocular lens? (pseudophakia) YES NO If "Yes," indicate eye Right Left Both

b. Is there aphakia or dislocation of the crystalline lens? YES NO

If "Yes," indicate eye: Right Left Both

c. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the eye conditions checked above in this section?

YES NO There is no decrease in visual acuity or other visual impairment

If "Yes," specify condition in this section responsible for visual impairment: _____

If "No," explain: _____

8. RETINA, MACULA, OR VITREOUS CONDITIONS

a. Indicate retina, macula, or vitreous condition and eye affected:

- Diabetic retinopathy (including proliferative and nonproliferative types) Right Left Both
 Retinopathy, not otherwise specified Right Left Both
 Maculopathy, not otherwise specified Right Left Both
 Localized retinal scars, atrophy, or irregularities, that are centrally located and result in an irregular, duplicated, enlarged, or diminished image Right Left Both
 Detachment of retina Right Left Both
 Retinal dystrophy (including retinitis pigmentosa, wet or dry macular degeneration, early-onset macular degeneration, rod and/or cone dystrophy) Right Left Both
 Other (Describe): _____ Right Left Both

b. Is the Veteran's decrease in visual acuity or other visual impairment attributable to a retina, macula, or vitreous condition?

YES NO There is no decrease in visual acuity or other visual impairment

If "Yes," specify the retina, macula, or vitreous condition(s) responsible for visual impairment: _____

If "No," explain: _____

SECTION IV - EYE CONDITIONS (Continued)

9. NEURO-OPHTHALMIC CONDITIONS

a. Indicate the Veteran's condition and side affected:

- Checkboxes for conditions: Ptosis, Optic neuropathy, Paralysis of accommodation due to neuropathy of the oculomotor nerve (3rd cranial nerve), Post-chiasmal disorders. Checkboxes for sides: Right, Left, Both.

If there is a post-chiasmal disorder, indicate the underlying cause:

- Checkboxes for underlying causes: Cerebrovascular accident (CVA), Demyelinating disease, Intracranial mass/tumor, Traumatic Brain Injury (TBI), Alzheimer's Disease, Other - Specify the underlying neurologic condition (for example: Jakob-Creutzfeldt disease, etc.):

b. Does the Veteran have nystagmus? YES NO

If "Yes," is it central? YES NO

c. Is the Veteran's decrease in visual acuity or other visual impairment attributable to a neuro-ophthalmic condition?

- Checkboxes for visual impairment: YES, NO, There is no decrease in visual acuity or other visual impairment

If "Yes," specify the neuro-ophthalmic condition(s) responsible for visual impairment:

If "No," explain:

10. OCULAR NEOPLASMS

a. Indicate the Veteran's condition and eye affected:

- Checkboxes for conditions: Malignant neoplasm of the eye, orbit, or adnexa (excluding skin), Benign neoplasm of the eye, orbit, or adnexa (excluding skin), Other (Describe):. Checkboxes for sides: Right, Left, Both.

b. Is the Veteran's decrease in visual acuity or other visual impairment attributable to an eye neoplasm condition?

- Checkboxes for visual impairment: YES, NO, There is no decrease in visual acuity or other visual impairment

If "Yes," specify the neoplasm condition responsible for visual impairment:

If "No," explain:

c. Is the neoplasm active or in remission?

- Checkboxes for status: Active, Remission

d. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm of the eye, orbit, or adnexa (excluding skin) or metastases?

- Checkboxes for treatment: Yes, No, watchful waiting

If "Yes," indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

- Checkboxes for treatment types: Treatment completed; currently in watchful waiting status, Surgery (more extensive than enucleation) with fields for name, date, and description, Radiation therapy (to include, but not limited to x-ray therapy more extensive than to the area of the eye) with fields for date and completion, Systemic chemotherapy with fields for date and completion.

SECTION IV - EYE CONDITIONS (Continued)

10. OCULAR NEOPLASMS (Continued)

Other therapeutic procedure

Name or description of procedure: _____

Date of most recent procedure: _____

e. 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?

YES NO

If "Yes," list residual conditions and complication (brief summary):

11. TRAUMA / HEMORRHAGE

a. Indicate the Veteran's condition and eye affected:

Intraocular hemorrhage Right Left Both

Unhealed eye injury, inclusive of orbital trauma as well as penetrating and non-penetrating eye injury Right Left Both

Other (Describe): _____ Right Left Both

b. Is the Veteran's decrease in visual acuity or other visual impairment attributable to an eye hemorrhage or trauma?

YES NO There is no decrease in visual acuity or other visual impairment

If "Yes," specify the hemorrhage or trauma condition responsible for visual impairment: _____

If "No," explain: _____

12. OTHER EYE CONDITION(S) NOT COVERED BY ITEMS 2 THROUGH 11

a. Does the Veteran have any other eye conditions, pertinent physical findings, complications, signs, and/or symptoms related to a current eye diagnosis?

YES NO

If "Yes," describe:

b. Is the Veteran's decrease in visual acuity or other visual impairment attributable to this condition?

YES NO There is no decrease in visual acuity or other visual impairment

If "Yes," specify the condition(s) responsible for visual impairment: _____

If "No," explain: _____

SECTION V - SCARRING AND DISFIGUREMENT

1. DOES THE VETERAN HAVE SCARRING OR DISFIGUREMENT ATTRIBUTABLE TO ANY EYE CONDITION?

YES NO (If "Yes," complete appropriate dermatological DBQ)

SECTION VI - INCAPACITATING EPISODES

NOTE: For the purposes of evaluation under 38 CFR 4.79, an incapacitating episode is an eye condition serious enough to require a clinic visit to a provider specifically for treatment purposes. Examples of treatment may include but are not limited to: Systemic immunosuppressants or biologic agents; intravitreal or periocular injections; laser treatments; or other surgical interventions.

1. During the past 12 months, has the Veteran had any incapacitating episodes attributable to an eye condition?

YES NO

If "Yes," specify the eye condition(s) causing incapacitating episodes:

2. Indicate the number of DOCUMENTED medical visits for treatment of an eye condition over the past 12 months:

- At least 1 but less than 3
- At least 3 but less than 5
- At least 5 but less than 7
- 7 or more

3. Indicate the type of intervention that occurred during the incapacitating episode (Check all that apply):

- Systemic immunosuppressant or biologic agent (name of medication): _____
- Intravitreal or periocular injections (name of medication): _____
- Laser treatments
- Surgical intervention (Describe): _____
- Other (Describe): _____

SECTION VII - FUNCTIONAL IMPACT

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

YES NO

If "Yes," describe the impact of each of the Veteran's eye condition(s), providing one or more examples:

SECTION VIII - REMARKS

8. REMARKS *(If any)*

SECTION IX - EXAMINER'S CERTIFICATION AND SIGNATURE

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

9A. Examiner's signature:

9B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

9C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

9D. Date Signed:

9E. Examiner's phone/fax numbers:

9F. National Provider Identifier (NPI) number:

9G. Medical license number and state:

9H. Examiner's address: