

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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

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

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

Veteran/Claimant

Other: please describe

Are you a VA Healthcare provider? Yes No

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

Was the Veteran examined in person? Yes No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

No records were reviewed

Records reviewed

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

SECTION I - DIAGNOSIS

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

YES NO

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

INGUINAL HERNIA *(If checked, complete Section III.1)* ICD code: _____ Date of diagnosis: _____

FEMORAL HERNIA *(If checked, complete Section III.2)* ICD code: _____ Date of diagnosis: _____

VENTRAL HERNIA *(If checked, complete Section III.3)* ICD code: _____ Date of diagnosis: _____

OTHER *(Specify)*:
 OTHER DIAGNOSIS #1: _____ ICD code: _____ Date of diagnosis: _____
 _____ ICD code: _____ Date of diagnosis: _____
 OTHER DIAGNOSIS #2: _____ ICD code: _____ Date of diagnosis: _____
 _____ ICD code: _____ Date of diagnosis: _____

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

SECTION II - MEDICAL HISTORY

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

SECTION III - HERNIA CONDITIONS

1. INGUINAL HERNIA

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

Surgery performed *(Indicate side)*:
 Right: Date and type of surgery: _____
 Left: Date and type of surgery: _____

No previous surgery but hernia appears operable and remediable *(Indicate side)*: Right: Left:

Irremediable, provide reason: _____ *(Indicate side)*: Right: Left:

Inoperable, provide reason: _____ *(Indicate side)*: Right: Left:

Recurrent hernia following surgical repair *(Indicate status of postoperative recurrent hernia)*:
 Recurrent hernia appears operable and remediable *(If checked, indicate side)*: Right: Left:
 Irremediable, provide reason: _____ *(Indicate side)*: Right: Left:
 Inoperable, provide reason: _____ *(Indicate side)*: Right: Left:

B. EXAM

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

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

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

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

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

SECTION III - HERNIA CONDITIONS (Continued)

2. FEMORAL HERNIA

A. SURGICAL STATUS (check all that apply):

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

B. EXAM

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

C. ABILITY TO BE REDUCED

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

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

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

3. VENTRAL HERNIA

A. SURGICAL STATUS (check all that apply):

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

B. EXAM (check all that apply):

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

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

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

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

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

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

YES NO

IF YES, DESCRIBE (*brief summary*):

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

YES NO

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

YES NO

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

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

LOCATION: _____ MEASUREMENTS: length _____ cm X width _____ cm.

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

1C. COMMENTS, IF ANY:

2. DIAGNOSTIC TESTING

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

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

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

3. FUNCTIONAL IMPACT

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

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

4. REMARKS

REMARKS (*If any*):

SECTION V - EXAMINER'S CERTIFICATION AND SIGNATURE

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

5A. Examiner's signature:

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

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

5D. Date Signed:

5E. Examiner's phone/fax numbers:

5F. National Provider Identifier (NPI) number:

5G. Medical license number and state:

5H. Examiner's address: