



Name of Claimant/Veteran

Claimant/Veteran's Social Security Number

Date of Examination

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

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

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

[ ] Veteran/Claimant

[ ] Other: please describe

Text input 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?

Text input 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 text input box for evidence review details

SECTION I - DIAGNOSIS

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

Note: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in comments 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.

**SECTION I - DIAGNOSIS (continued)**

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 comments section.)

Note: If any condition is checked below, complete all of Section 1, Section 2, and also the applicable Section(s) 3 through 11 with which the condition is most associated.

Diagnosis:	Side affected:			ICD Code:	Date of diagnosis:	
<input type="checkbox"/> Flat foot (pes planus)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Plantar fasciitis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Morton's neuroma	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Metatarsalgia	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Hammer toes	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Hallux valgus	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Hallux rigidus	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Acquired pes cavus (claw foot)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Malunion/nonunion of tarsal/ metatarsal bones	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Foot injury(ies), specify:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
 <input type="checkbox"/> Arthritic conditions:						
<input type="checkbox"/> Arthritis, degenerative, other than post-traumatic	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, gonorrheal	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, pneumococcic	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, streptococcic	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, syphilitic	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, multi-joint (except post-traumatic and gout), as an active process	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, post-traumatic	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, typhoid	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, other specified forms of arthropathy (excluding gout)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
 <input type="checkbox"/> Inflammatory conditions:						
<input type="checkbox"/> Osteoporosis, residuals of	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Osteomalacia, residuals of	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Bones, neoplasm, benign	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Bones, neoplasm, malignant, primary or secondary	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Osteitis deformans	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Gout	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Myositis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Myositis ossificans	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Other specified forms:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
 <input type="checkbox"/> Tendinopathy (select one if known)						
<input type="checkbox"/> Tendinitis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Tendinosis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Tenosynovitis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
 <input type="checkbox"/> Other, specify:						
<input type="checkbox"/> Diagnosis #1	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Diagnosis #2	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Diagnosis #3	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____

**SECTION I - DIAGNOSIS (continued)**

1C. If there are additional diagnoses that pertain to foot conditions, list using above format:

**SECTION II - MEDICAL HISTORY**

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

2B. Does the Veteran report pain of the foot being evaluated on this questionnaire?

Yes  No

If yes, document the Veteran's description of pain in his or her own words:

2C. Does the Veteran report that flare-ups impact the function of the foot?

Yes  No

If so, ask the Veteran to describe the flare-ups he or she experiences, including the frequency, duration, characteristics, precipitating and alleviating factors, severity and/or extent of functional impairment he or she experiences during a flare-up of symptoms.

2D. 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 repeated use over time?

Yes  No

If yes, document the Veteran's description of functional loss or functional impairment in his/her own words:

**SECTION III - FLATFOOT (PES PLANUS)**

Note: Indicate all signs and symptoms that apply to the Veteran's flatfoot (pes planus) condition, regardless of whether similar signs and symptoms appear more than once in different sections.

3A. Does the Veteran have pain on use of the feet?

Yes  No

If yes, indicate side affected:  Right  Left  Both

If yes, is the pain accentuated on use?  Yes  No

If yes, indicate side affected:  Right  Left  Both

3B. Does the Veteran have pain on manipulation of the feet?

Yes  No

If yes, indicate side affected:  Right  Left  Both

If yes, is the pain accentuated on manipulation?  Yes  No

If yes, indicate side affected:  Right  Left  Both

**SECTION III - FLATFOOT (PES PLANUS) (continued)**

3C. Is there indication of swelling on use?

Yes     No

If yes, indicate side affected:

Right     Left     Both

3D. Does the Veteran have characteristic calluses?

Yes     No

If yes, indicate side affected:

Right     Left     Both

3E. Effects of use of arch supports or built-up shoes

Effecting Complete Relief of Symptoms		Tried But Remains Symptomatic	
Device	Side Relieved	Device	Side Not Relieved
<input type="checkbox"/> Arch Supports	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Arch Supports	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Built-up Shoes	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Built-up Shoes	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both

3F. Does the Veteran have extreme tenderness of plantar surfaces on one or both feet?

Yes     No

If yes, indicate side affected:

Right     Left     Both

Is the tenderness improved by orthopedic shoes or appliances?

Right     Yes     No     N/A

Left     Yes     No     N/A

3G. Does the Veteran have decreased longitudinal arch height of one or both feet on weight-bearing?

Yes     No

If yes, indicate side affected:

Right     Left     Both

3H. Is there objective evidence of marked deformity of one or both feet (pronation, abduction, etc.)?

Yes     No

If yes, indicate side affected:

Right     Left     Both

3I. Is there marked pronation of one foot or both feet?

Yes     No

If yes, indicate side affected:

Right     Left     Both

Is the condition improved by orthopedic shoes or appliances?

Right     Yes     No     N/A

Left     Yes     No     N/A

**SECTION III - FLATFOOT (PES PLANUS) (continued)**

3J. For one or both feet, is the weight-bearing line over or medial to the great toe?

Yes  No

If yes, indicate side affected:

Right  Left  Both

3K. Is there a lower extremity deformity other than pes planus, causing alteration of the weight-bearing line?

Yes  No

If yes, indicate side affected:

Right  Left  Both

Describe lower extremity deformity other than pes planus causing alteration of the weight-bearing line:

3L. Does the Veteran have "inward" bowing of the Achilles' tendon (i.e., hindfoot valgus, with lateral deviation of the heel) of one or both feet?

Yes  No

If yes, indicate side affected:

Right  Left  Both

3M. Does the Veteran have marked inward displacement and severe spasm of the Achilles' tendon (rigid hindfoot) on manipulation of one or both feet?

Yes  No

If yes, indicate side affected:

Right  Left  Both

Is the marked inward displacement and severe spasm of the Achilles' tendon improved by orthopedic shoes or appliances?

Right  Yes  No  N/A

Left  Yes  No  N/A

3N. Comments, if any:

**SECTION IV - PLANTAR FASCIITIS**

4A. Has the Veteran undergone non-surgical treatment for plantar fasciitis?

Yes  No

If yes, indicate side:

Right  Left  Both

4B. If yes, did the non-surgical treatment relieve the symptoms?

Yes  No

If no, indicate side not relieved:

Right  Left  Both

**SECTION IV - PLANTAR FASCIITIS (continued)**

4C. Has the Veteran undergone surgical treatment for plantar fasciitis?

Yes  No (if no, proceed to 4E)

If yes, indicate side:

Right  Left  Both

4D. If yes, did the surgical treatment relieve the symptoms?

Yes  No

If no, indicate side not relieved:

Right  Left  Both

4E. If the Veteran has not undergone surgical treatment, was the Veteran recommended for surgical intervention, but was not a surgical candidate?

Yes  No

If yes, indicate side:

Right  Left  Both

4F. Does the Veteran have any functional loss of the foot/feet due to plantar fasciitis?

Yes  No

If yes, indicate side affected:

Right  Left  Both

Describe the functional loss of the foot/feet due to plantar fasciitis:

4G. Comments, if any:

**SECTION V - MORTON'S NEUROMA (MORTON'S DISEASE) AND METATARSALGIA**

5A. Does the Veteran have Morton's neuroma?

Yes  No

If yes, indicate side affected:

Right  Left  Both

5B. Does the Veteran have metatarsalgia?

Yes  No

If yes, indicate side affected:

Right  Left  Both

**SECTION V - MORTON'S NEUROMA (MORTON'S DISEASE) AND METATARSALGIA (continued)**

5C. Comments, if any:

**SECTION VI - HAMMER TOE**

6A. If the Veteran has hammer toes, which toes are affected?

Right:  None  Great toe  Second toe  Third toe  Fourth toe  Little toe  
Left:  None  Great toe  Second toe  Third toe  Fourth toe  Little toe

6B. Comments, if any:

**SECTION VII - HALLUX VALGUS**

7A. Does the Veteran have symptoms due to a hallux valgus condition?

Yes  No

If yes, indicate severity (check all that apply):

Mild or moderate symptoms

Side affected:  Right  Left  Both

Severe symptoms, with function equivalent to amputation of great toe

Side affected:  Right  Left  Both

7B. Has the Veteran had surgery for hallux valgus?

Yes  No

If yes, indicate type and date of surgery and side affected:

Resection of metatarsal head

Date of surgery: \_\_\_\_\_ Side affected:  Right  Left  Both

Tarsal osteotomy/metatarsal head osteotomy (equivalent to metatarsal head resection)

Date of surgery: \_\_\_\_\_ Side affected:  Right  Left  Both

Other surgery for hallux valgus, describe: \_\_\_\_\_

Date of surgery: \_\_\_\_\_ Side affected:  Right  Left  Both

7C. Comments, if any:

**SECTION VIII - HALLUX RIGIDUS**

8A. Does the Veteran have symptoms due to hallux rigidus?

Yes     No

If yes, indicate severity (check all that apply):

Mild or moderate symptoms

Side affected:     Right     Left     Both

Severe symptoms, with function equivalent to amputation of great toe

Side affected:     Right     Left     Both

8B. Comments, if any:

**SECTION IX - ACQUIRED PES CAVUS (CLAW FOOT)**

9A. Effect on toes due to pes cavus (check all that apply):

- |   |                                |                               |                               |
|---|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> None   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Great toe dorsiflexed  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> All toes tending to dorsiflexion   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> All toes hammer toes   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, describe (if there is an effect on toes due to etiology other than pes cavus, indicate other etiology): |                                |                               |                               |

9B. Pain and tenderness due to pes cavus (check all that apply):

- |  |                                |                               |                               |
|--|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> None  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Definite tenderness under metatarsal heads  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Marked tenderness under metatarsal heads  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Very painful callosities  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, describe (if the Veteran has pain and tenderness due to etiology other than pes cavus, indicate other etiology): |                                |                               |                               |

9C. Effect on plantar fascia due to pes cavus (check all that apply):

- |   |                                |                               |                               |
|---|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> None   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Shortened plantar fascia   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Marked contraction of plantar fascia with dropped forefoot   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, describe (if there is an effect on plantar fascia due to etiology other than pes cavus, indicate other etiology): |                                |                               |                               |



**SECTION IX - ACQUIRED PES CAVUS (CLAW FOOT) (continued)**

9D. Dorsiflexion and varus deformity due to pes cavus (check all that apply):

- |   |                                |                               |                               |
|---|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> None   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Some limitation of dorsiflexion at ankle   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Limitation of dorsiflexion at ankle to right angle   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Marked varus deformity   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, describe (if the Veteran has dorsiflexion and varus deformity due to etiology other than pes cavus, indicate other etiology): |                                |                               |                               |

9E. Comments, if any:

**SECTION X - MALUNION OR NONUNION OF TARSAL OR METATARSAL BONES**

10A. Indicate severity and side affected for malunion or nonunion of tarsal or metatarsal bones:

- |  |                                |                               |                               |
|--|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Moderate          | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Moderately severe | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Severe            | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

10B. Comments, if any:

**SECTION XI - FOOT INJURIES AND OTHER CONDITIONS**

Note: Complete this section if the Veteran has any foot injuries or other foot conditions listed in Section 1B not already described above in Sections 3 through 10.

Note: For VA purposes "bilateral weak foot" describes a symptomatic condition secondary to many constitutional conditions, and is characterized by atrophy of the musculature, disturbed circulation and weakness.

11A. Does the Veteran have any foot injuries or other foot conditions not already described?

- Yes     No

If yes, describe the foot injury or other foot conditions (including frequency and physical exam findings) and complete question 11B (severity and side affected).

11B. Indicate severity and side affected.

- |  |                                |                               |                               |
|--|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Not affected      | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Mild              | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Moderate          | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Moderately severe | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Severe            | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

**SECTION XI - FOOT INJURIES AND OTHER CONDITIONS** (continued)

11C. Does the foot condition chronically compromise weight-bearing?

Yes     No

11D. Does the foot condition require arch supports, custom orthotic inserts or shoe modifications?

Yes     No

11E. Comments, if any:

**SECTION XII - SURGICAL PROCEDURES**

Note: Complete this section if the Veteran has had any surgical procedures for the claimed condition that have not already been described.

12A. Has the Veteran had foot surgery (arthroscopic or open)?

Yes     No

If yes, indicate side affected, type of procedure and date of surgery.

Right foot procedure: \_\_\_\_\_

Date of surgery: \_\_\_\_\_

Left foot procedure: \_\_\_\_\_

Date of surgery: \_\_\_\_\_

12B. Does the Veteran have any residual signs or symptoms due to arthroscopic or other foot surgery?

Yes     No

If yes, describe residuals:

**SECTION XIII - PAIN**

Foot	Is there pain on physical exam?	If no, but the Veteran reported pain in his/her medical history, please provide rationale below.	If yes (there is pain on physical exam), does the pain contribute to functional loss?	If no (i.e., the pain does not contribute to functional loss or additional limitations), explain why:
Right Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes (you will be asked to further describe these limitations in Section 14) <input type="checkbox"/> No	
Left Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes (you will be asked to further describe these limitations in Section 14) <input type="checkbox"/> No	

**SECTION XIV - FUNCTIONAL LOSS**

Note: VA defines functional loss as the inability, due to damage or infection in parts of the system, to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance. As regards the joints, factors of disability reside in reductions of their normal excursion of movements in different planes.

Using information 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), the examiner's medical expertise, and physical exam, select the factors below that contribute to functional loss or impairment (regardless of repetitive use) or to additional limitation of range of motion (ROM) after repetitive use for the joint or extremity being evaluated on this questionnaire:

14A. Contributing factors of disability (check all that apply and indicate side affected):

- |  |                                |                               |                               |
|--|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> No functional loss for <u>left</u> lower extremity attributable to claimed condition  |                                |                               |                               |
| <input type="checkbox"/> No functional loss for <u>right</u> lower extremity attributable to claimed condition |                                |                               |                               |
| <input type="checkbox"/> Less movement than normal   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> More movement than normal   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Weakened movement   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Swelling  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Deformity   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Atrophy of disuse   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Instability of station  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Disturbance of locomotion   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Interference with sitting   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Interference with standing  | <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"/> Fatigue   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Weakness  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Lack of endurance   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Incoordination  | <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 |

14B. Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability during flare-ups and/or after repeated use over time?

- Yes     No

If yes, indicate side affected:

- Right     Left     Both

If yes (there is a functional loss due to pain, during flare-ups and/or after repeated use over time), please describe the functional loss as well as cite and discuss evidence (must be specific to the case and based on all procurable evidence):

**SECTION XIV - FUNCTIONAL LOSS (continued)**

14C. Is there any other functional loss during flare-ups and/or after repeated use over time?

Yes     No

If yes, indicate side affected:

Right     Left     Both

If yes, describe:

Note: For any joint condition, unless medically contraindicated, the examiner should address pain on both passive and active motion, and on both weight-bearing and nonweight-bearing. These factors must be assessed for the claimed foot and the contralateral foot (even if the contralateral foot is unclaimed). Specific joint range of motion measurements in degrees do not need to be documented.

14D. Is there evidence of pain on any of the following? (check all that apply)

<input type="checkbox"/> Passive motion	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Active motion	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Weight-bearing	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Nonweight-bearing	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> On rest/non-movement	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both

If yes, describe:

If unable to assess, a rationale is required (e.g., the foot is in a cast; the contralateral unclaimed foot is damaged; etc.):

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

15A. 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):

15B. 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, complete appropriate dermatological questionnaire.

**SECTION XVI - ASSISTIVE DEVICES**

16A. Does the Veteran use any assistive devices (other than those identified above) 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):

- |                                       |                   |                                     |                                  |                                   |
|---------------------------------------|-------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Wheelchair   | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Brace        | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Crutches     | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Cane         | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Walker       | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Other: _____ | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |

16B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition:

**SECTION XVII - 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.

17A. Due to the Veteran's foot 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

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

**SECTION XVIII - DIAGNOSTIC TESTING**

Note: Testing listed below is not indicated for every condition. Plain or weight-bearing foot x-rays are not required to make the diagnosis of flatfoot. 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.

18A. Have imaging studies been performed in conjunction with this examination?

- Yes  No

18B. If yes, is degenerative or post-traumatic arthritis documented?

- Yes  No

If yes, indicate foot:

- Right  Left  Both

18C. If yes, provide type of test or procedure, date and results (brief summary):

**SECTION XVIII - DIAGNOSTIC TESTING**

18D. 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):

18E. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

**SECTION XIX - 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.

19A. Regardless of the Veteran's current employment status, do the condition(s) listed in the diagnosis section impact his or her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?

Yes  No

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

**SECTION XX- REMARKS**

20A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

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

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

21A. Examiner's signature:

21B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

21C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

21D. Date Signed:

21E. Examiner's phone/fax numbers:

21F. National Provider Identifier (NPI) number:

21G. Medical license number and state:

21H. Examiner's address: