



Name of Patient/Veteran

Patient/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 completed questionnaires. **It is intended that this questionnaire will be completed by the Veteran's healthcare provider.**

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

Veteran/Claimant

Third party (please list name(s) of organization(s) or individual(s))

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 1 - DIAGNOSIS

Note: These are condition(s) for which an evaluation has been requested on 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:

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(s), 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 condition(s) listed above. (Explain your findings and reasons in the Remarks section)

	Side affected:	ICD code:	Date of diagnosis:
<input type="checkbox"/> Lateral collateral ligament sprain (chronic/recurrent)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Deltoid ligament sprain (chronic/recurrent)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Osteochondritis dissecans to include osteochondral fracture	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Impingement (anterior/posterior (or trigonum syndrome)/anterolateral)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Tendonitis (Achilles/peroneal/posterior tibial)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Retrocalcaneal bursitis	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Achilles' tendon rupture	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Avascular necrosis, talus	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Ankle joint replacement	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Ankylosis of ankle, subtalar or tarsal joint	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Shin splints/medial tibial stress syndrome - MTSS (including post-surgery or treatment)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____

Note: If shin splints is diagnosed with compartment syndrome complete the Muscles questionnaire in lieu of this questionnaire.

<input type="checkbox"/> Degenerative arthritis, other than post-traumatic	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, gonorrheal	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, pneumococcal	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, streptococcal	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, syphilitic	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, rheumatoid (multi-joints)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, post-traumatic	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, typhoid	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Other specified forms of arthropathy (excluding gout):			
	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Osteoporosis, residuals of	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Osteomalacia, residuals of	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Bones, neoplasm, benign	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Bones, neoplasm, malignant, primary or secondary	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Osteitis deformans	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Gout	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Bursitis	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____

<input type="checkbox"/> Myositis	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
<input type="checkbox"/> Heterotopic ossification	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
<input type="checkbox"/> Tendinopathy (select one if known)	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
<input type="checkbox"/> Tendinitis	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
<input type="checkbox"/> Tendinosis	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
<input type="checkbox"/> Tenosynovitis	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
<input type="checkbox"/> Other (specify): _____					
Other diagnosis #1: _____	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
Other diagnosis #2: _____	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
Other diagnosis #3: _____	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____

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

## SECTION 2 - MEDICAL HISTORY

2A. Describe the history, including onset and course, of the Veteran's ankle condition(s). Brief summary:

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

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:

2D. Does the Veteran report or have a history of instability of the ankle?

Yes     No

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

### SECTION 3 - 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 ANKLE	LEFT ANKLE
3A. Initial ROM measurements  <input type="radio"/> All Normal <input type="radio"/> Abnormal or outside of normal range  <input type="radio"/> Unable to test <input type="radio"/> Not indicated	3A. Initial ROM measurements  <input type="radio"/> All Normal <input type="radio"/> Abnormal or outside of normal range  <input type="radio"/> Unable to test <input type="radio"/> Not indicated
If "Unable to test" or "Not indicated", please explain: <div style="border: 1px solid black; height: 150px; width: 100%;"></div>	
If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than an ankle condition, such as age, body habitus, neurologic disease), please describe: <div style="border: 1px solid black; height: 150px; width: 100%;"></div>	

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

Yes  No

If yes, please explain:

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

Yes  No

If yes, please explain:

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:

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.

Plantar flexion endpoint (45 degrees): \_\_\_\_\_ degrees

Dorsiflexion endpoint (20 degrees): \_\_\_\_\_ degrees

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

Plantar flexion  Dorsiflexion

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.

Plantar flexion degree endpoint (if different than above)

\_\_\_\_\_

Dorsiflexion degree endpoint (if different than above)

\_\_\_\_\_

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

Plantar flexion endpoint (45 degrees): \_\_\_\_\_ degrees  Same as active ROM

Dorsiflexion endpoint (20 degrees): \_\_\_\_\_ degrees  Same as active ROM

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

Plantar flexion  Dorsiflexion

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.

Plantar flexion endpoint (45 degrees): \_\_\_\_\_ degrees

\_\_\_\_\_

Dorsiflexion endpoint (20 degrees): \_\_\_\_\_ degrees

\_\_\_\_\_

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

Plantar flexion  Dorsiflexion

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.

Plantar flexion degree endpoint (if different than above)

\_\_\_\_\_

Dorsiflexion degree endpoint (if different than above)

\_\_\_\_\_

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

Plantar flexion endpoint (45 degrees): \_\_\_\_\_ degrees  Same as active ROM

Dorsiflexion endpoint (20 degrees): \_\_\_\_\_ degrees  Same as active ROM

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

Plantar flexion  Dorsiflexion

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.

Plantar flexion degree endpoint (if different than above)

Dorsiflexion degree endpoint (if different than above)

Is there evidence of pain?  Yes  No

If yes, check all that apply.

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

Comments:

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).

### 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:

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.

Plantar flexion degree endpoint (if different than above)

Dorsiflexion degree endpoint (if different than above)

Is there evidence of pain?  Yes  No

If yes, check all that apply.

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

Comments:

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).

### 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:

<p>Is there additional loss of function or range of motion after three repetitions?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, please respond to the following after the completion of the three repetitions:</p> <p>Plantar flexion endpoint (45 degrees): _____ degrees</p> <p>Dorsiflexion endpoint (20 degrees): _____ degrees</p> <p>Select factors that cause this functional loss. Check all that apply.</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A</p>	<p>Is there additional loss of function or range of motion after three repetitions?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, please respond to the following after the completion of the three repetitions:</p> <p>Plantar flexion endpoint (45 degrees): _____ degrees</p> <p>Dorsiflexion endpoint (20 degrees): _____ degrees</p> <p>Select factors that cause this functional loss. Check all that apply.</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A</p>
<p>Note: When pain is associated with movement, the examiner must give a statement on whether pain could significantly limit functional ability during flare-ups and/or after repeated use over time in terms of additional loss of range of motion. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare-ups - even if not directly observed during a flare-up and/or after repeated use over time.</p>	
<p><b>3C. Repeated use over time</b></p> <p>Is the Veteran being examined immediately after repeated use over time?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select factors that cause this functional loss. Check all that apply.</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A</p> <p>Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran.</p> <p>Plantar flexion endpoint (45 degrees): _____ degrees</p> <p>Dorsiflexion endpoint (20 degrees): _____ degrees</p> <p>The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.</p> <p>Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>	<p><b>3C. Repeated use over time</b></p> <p>Is the Veteran being examined immediately after repeated use over time?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select factors that cause this functional loss. Check all that apply.</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A</p> <p>Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran.</p> <p>Plantar flexion endpoint (45 degrees): _____ degrees</p> <p>Dorsiflexion endpoint (20 degrees): _____ degrees</p> <p>The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.</p> <p>Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>
<p><b>3D. Flare-ups</b></p> <p>Is the examination being conducted during a flare-up?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare-ups?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select factors that cause this functional loss. Check all that apply.</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A</p>	<p><b>3D. Flare-ups</b></p> <p>Is the examination being conducted during a flare-up?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare-ups?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select factors that cause this functional loss. Check all that apply.</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Fatigability <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A</p>

<p>Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran.</p> <p>Plantar flexion endpoint (45 degrees): _____ degrees</p> <p>Dorsiflexion endpoint (20 degrees): _____ degrees</p> <p>The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.</p> <p>Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	<p>Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran.</p> <p>Plantar flexion endpoint (45 degrees): _____ degrees</p> <p>Dorsiflexion endpoint (20 degrees): _____ degrees</p> <p>The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.</p> <p>Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>																												
<p><b>3E. Additional factors contributing to disability</b></p> <p>In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding-bottom: 10px;"><input type="checkbox"/> None</td> <td style="width: 50%; padding-bottom: 10px;"><input type="checkbox"/> Interference with sitting</td> </tr> <tr> <td><input type="checkbox"/> Interference with standing</td> <td><input type="checkbox"/> Swelling</td> </tr> <tr> <td><input type="checkbox"/> Disturbance of locomotion</td> <td><input type="checkbox"/> Deformity</td> </tr> <tr> <td><input type="checkbox"/> Less movement than normal</td> <td><input type="checkbox"/> More movement than normal</td> </tr> <tr> <td><input type="checkbox"/> Weakened movement</td> <td><input type="checkbox"/> Atrophy of disuse</td> </tr> <tr> <td><input type="checkbox"/> Instability of station</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other, describe: _____</td> <td></td> </tr> </table> <p>Please describe additional contributing factors of disability:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	<input type="checkbox"/> None	<input type="checkbox"/> Interference with sitting	<input type="checkbox"/> Interference with standing	<input type="checkbox"/> Swelling	<input type="checkbox"/> Disturbance of locomotion	<input type="checkbox"/> Deformity	<input type="checkbox"/> Less movement than normal	<input type="checkbox"/> More movement than normal	<input type="checkbox"/> Weakened movement	<input type="checkbox"/> Atrophy of disuse	<input type="checkbox"/> Instability of station		<input type="checkbox"/> Other, describe: _____		<p><b>3E. Additional factors contributing to disability</b></p> <p>In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding-bottom: 10px;"><input type="checkbox"/> None</td> <td style="width: 50%; padding-bottom: 10px;"><input type="checkbox"/> Interference with sitting</td> </tr> <tr> <td><input type="checkbox"/> Interference with standing</td> <td><input type="checkbox"/> Swelling</td> </tr> <tr> <td><input type="checkbox"/> Disturbance of locomotion</td> <td><input type="checkbox"/> Deformity</td> </tr> <tr> <td><input type="checkbox"/> Less movement than normal</td> <td><input type="checkbox"/> More movement than normal</td> </tr> <tr> <td><input type="checkbox"/> Weakened movement</td> <td><input type="checkbox"/> Atrophy of disuse</td> </tr> <tr> <td><input type="checkbox"/> Instability of station</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other, describe: _____</td> <td></td> </tr> </table> <p>Please describe additional contributing factors of disability:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	<input type="checkbox"/> None	<input type="checkbox"/> Interference with sitting	<input type="checkbox"/> Interference with standing	<input type="checkbox"/> Swelling	<input type="checkbox"/> Disturbance of locomotion	<input type="checkbox"/> Deformity	<input type="checkbox"/> Less movement than normal	<input type="checkbox"/> More movement than normal	<input type="checkbox"/> Weakened movement	<input type="checkbox"/> Atrophy of disuse	<input type="checkbox"/> Instability of station		<input type="checkbox"/> Other, describe: _____	
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<input type="checkbox"/> Other, describe: _____																													
<b>SECTION 4 - MUSCLE ATROPHY</b>																													
<p><b>4A. Does the Veteran have muscle atrophy?</b></p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p><b>4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section?</b></p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>If no, provide rationale:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	<p><b>4A. Does the Veteran have muscle atrophy?</b></p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p><b>4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section?</b></p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>If no, provide rationale:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>																												

<p>4C. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.</p> <p><input type="checkbox"/> Right lower extremity (specify location of measurement such as "1cm above or below ankle"):</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	<p>4C. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.</p> <p><input type="checkbox"/> Left lower extremity (specify location of measurement such as "1cm above or below ankle"):</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
<p>Circumference of more normal side: _____ cm</p> <p>Circumference of atrophied side: _____ cm</p>	<p>Circumference of more normal side: _____ cm</p> <p>Circumference of atrophied side: _____ cm</p>

## SECTION 5 - ANKYLOSIS

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

<p>5A. Is there ankylosis of the ankle? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, indicate the severity of ankle ankylosis:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> In plantar flexion, less than 30 degrees</li> <li><input type="checkbox"/> In plantar flexion, between 30 degrees and 40 degrees</li> <li><input type="checkbox"/> In plantar flexion at more than 40 degrees</li> <li><input type="checkbox"/> In dorsiflexion, between 0 degrees and 10 degree</li> <li><input type="checkbox"/> In dorsiflexion at more than 10 degrees</li> <li><input type="checkbox"/> With an abduction deformity</li> <li><input type="checkbox"/> With an adduction deformity</li> <li><input type="checkbox"/> With an inversion deformity</li> <li><input type="checkbox"/> With an eversion deformity</li> </ul>	<p>5A. Is there ankylosis of the ankle? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, indicate the severity of ankle ankylosis:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> In plantar flexion, less than 30 degrees</li> <li><input type="checkbox"/> In plantar flexion, between 30 degrees and 40 degrees</li> <li><input type="checkbox"/> In plantar flexion at more than 40 degrees</li> <li><input type="checkbox"/> In dorsiflexion, between 0 degrees and 10 degree</li> <li><input type="checkbox"/> In dorsiflexion at more than 10 degrees</li> <li><input type="checkbox"/> With an abduction deformity</li> <li><input type="checkbox"/> With an adduction deformity</li> <li><input type="checkbox"/> With an inversion deformity</li> <li><input type="checkbox"/> With an eversion deformity</li> </ul>
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<p>5B. Indicate angle of ankle ankylosis in <input type="checkbox"/> N/A no ankle ankylosis of joint degrees.</p> <p>Plantar flexion: _____</p> <p>Dorsiflexion: _____</p>	<p>5B. Indicate angle of ankle ankylosis in <input type="checkbox"/> N/A no ankle ankylosis of joint degrees.</p> <p>Plantar flexion: _____</p> <p>Dorsiflexion: _____</p>
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<p>5C. Is there ankylosis of the subastragalar or tarsal joint?</p> <p><input type="radio"/> Yes <input type="radio"/> No If yes, indicate severity:</p> <ul style="list-style-type: none"> <li><input type="radio"/> In good weight-bearing position</li> <li><input type="radio"/> In poor weight-bearing position</li> </ul>	<p>5C. Is there ankylosis of the subastragalar or tarsal joint?</p> <p><input type="radio"/> Yes <input type="radio"/> No If yes, indicate severity:</p> <ul style="list-style-type: none"> <li><input type="radio"/> In good weight-bearing position</li> <li><input type="radio"/> In poor weight-bearing position</li> </ul>
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## SECTION 6 - JOINT STABILITY

<p>6A. Complete the following:</p> <p>Anterior Drawer Test: Is there absence of firm end point with asymmetric or excessive motion?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unable to test</p>	<p>6A. Complete the following:</p> <p>Anterior Drawer Test: Is there absence of firm end point with asymmetric or excessive motion?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unable to test</p>
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<p>Talar Tilt Test: Is there asymmetric or excessive motion?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unable to test</p> <p>If unable to test, please explain why:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>	<p>Talar Tilt Test: Is there asymmetric or excessive motion?</p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> Unable to test</p> <p>If unable to test, please explain why:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>
<p>6B. If unable to test, is ankle instability suspected?   <input type="radio"/> Yes   <input type="radio"/> No</p> <p>If yes, please describe:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>	<p>6B. If unable to test, is ankle instability suspected?   <input type="radio"/> Yes   <input type="radio"/> No</p> <p>If yes, please describe:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>
<h3>SECTION 7 - ADDITIONAL COMMENTS</h3>	
<p>7A. Does the Veteran now have or has he or she ever had shin splints (medial tibial stress syndrome), stress fractures, Achilles tendonitis, Achilles tendon rupture, malunion of calcaneus (os calcis) or talus (astragalus), or has the Veteran had a tautectomy (astragalectomy)?</p> <p><input type="radio"/> Yes   <input type="radio"/> No</p> <p>If yes, indicate condition and complete the appropriate sections below:</p> <p><input type="checkbox"/> Stress fracture of the lower leg (If this affects ROM of the knee, please complete the appropriate musculoskeletal questionnaire and ROM section)</p> <p>Describe current symptoms:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>	<p>7A. Does the Veteran now have or has he or she ever had shin splints (medial tibial stress syndrome), stress fractures, Achilles tendonitis, Achilles tendon rupture, malunion of calcaneus (os calcis) or talus (astragalus), or has the Veteran had a tautectomy (astragalectomy)?</p> <p><input type="radio"/> Yes   <input type="radio"/> No</p> <p>If yes, indicate condition and complete the appropriate sections below:</p> <p><input type="checkbox"/> Stress fracture of the lower leg (If this affects ROM of the knee, please complete the appropriate musculoskeletal questionnaire and ROM section)</p> <p>Describe current symptoms:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>
<p><input type="checkbox"/> Achilles tendonitis or Achilles tendon rupture</p> <p>Describe current symptoms:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>	<p><input type="checkbox"/> Achilles tendonitis or Achilles tendon rupture</p> <p>Describe current symptoms:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>
<p><input type="checkbox"/> Malunion of calcaneus (os calcis) or talus (astragalus)</p> <p>Indicate severity:</p> <p><input type="radio"/> Moderate deformity</p> <p><input type="radio"/> Marked deformity</p> <p><input type="checkbox"/> "Shin Splints" (medial tibial stress syndrome - MTSS)</p> <p>Indicate length of treatment:</p> <p><input type="radio"/> no treatment received</p> <p><input type="radio"/> treatment for less than 12 consecutive months</p> <p><input type="radio"/> requiring treatment for 12 consecutive months or more</p>	<p><input type="checkbox"/> Malunion of calcaneus (os calcis) or talus (astragalus)</p> <p>Indicate severity:</p> <p><input type="radio"/> Moderate deformity</p> <p><input type="radio"/> Marked deformity</p> <p><input type="checkbox"/> "Shin Splints" (medial tibial stress syndrome - MTSS)</p> <p>Indicate length of treatment:</p> <p><input type="radio"/> no treatment received</p> <p><input type="radio"/> treatment for less than 12 consecutive months</p> <p><input type="radio"/> requiring treatment for 12 consecutive months or more</p>

If Veteran underwent treatment, indicate response to treatment:

- responsive to surgery and/or treatment
- unresponsive to either shoe orthotics or other conservative treatment
- unresponsive to surgery and either shoe orthotics or other conservative treatment

Does this condition affect ROM of knee?

- Yes (If yes, complete the Knee and Lower Leg Conditions questionnaire)
- No

Describe current symptoms:

- Talectomy

Describe current symptoms:

If Veteran underwent treatment, indicate response to treatment:

- responsive to surgery and/or treatment
- unresponsive to either shoe orthotics or other conservative treatment
- unresponsive to surgery and either shoe orthotics or other conservative treatment

Does this condition affect ROM of knee?

- Yes (If yes, complete the Knee and Lower Leg Conditions questionnaire)
- No

Describe current symptoms:

- Talectomy

Describe current symptoms:

## SECTION 8 - SURGICAL PROCEDURES

8A. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):

- No surgery
- Total ankle joint replacement

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

Residuals:

- None
- Intermediate degrees of residual weakness, pain or limitation of motion
- Chronic residuals consisting of severe painful motion or weakness
- Other, describe: \_\_\_\_\_

- Arthroscopic or other ankle surgery

Type of surgery: \_\_\_\_\_

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

8A. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):

- No surgery
- Total ankle joint replacement

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

Residuals:

- None
- Intermediate degrees of residual weakness, pain or limitation of motion
- Chronic residuals consisting of severe painful motion or weakness
- Other, describe: \_\_\_\_\_

- Arthroscopic or other ankle surgery

Type of surgery: \_\_\_\_\_

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

<input type="checkbox"/> Residuals of arthroscopic or other ankle surgery	<input type="checkbox"/> Residuals of arthroscopic or other ankle surgery
Describe residuals:	Describe residuals:
<div style="border: 1px solid black; height: 100px; width: 100%;"></div>	

#### SECTION 9 - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

9A. 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):

9B. 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 10 - ASSISTIVE DEVICES

10A. 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 the assistive devices used (check all that apply and indicate frequency):

<input type="checkbox"/> Wheelchair	Frequency of use:	<input type="radio"/> Occasional	<input type="radio"/> Regular	<input type="radio"/> Constant
<input type="checkbox"/> Brace(s)	Frequency of use:	<input type="radio"/> Occasional	<input type="radio"/> Regular	<input type="radio"/> Constant
<input type="checkbox"/> Crutch(es)	Frequency of use:	<input type="radio"/> Occasional	<input type="radio"/> Regular	<input type="radio"/> Constant
<input type="checkbox"/> Cane(s)	Frequency of use:	<input type="radio"/> Occasional	<input type="radio"/> Regular	<input type="radio"/> Constant
<input type="checkbox"/> Walker	Frequency of use:	<input type="radio"/> Occasional	<input type="radio"/> Regular	<input type="radio"/> Constant
<input type="checkbox"/> Other: _____	Frequency of use:	<input type="radio"/> Occasional	<input type="radio"/> Regular	<input type="radio"/> Constant

10B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

## SECTION 11 - 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.

11A. Due to the Veterans ankle 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

11B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

## SECTION 12 - 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.

12A. Have clinically relevant diagnostic imaging studies or other diagnostic procedures been performed or reviewed in conjunction with this examination?  Yes  No

12B. If yes, is degenerative or post-traumatic arthritis documented?  Yes  No

If yes, indicate side:  Right  Left  Both

12C. If yes, provide type of test or procedure, date and results (brief summary):

12D. Are there any other clinically relevant 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):

12E. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

### SECTION 13 - 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.

13A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?

Yes     No

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

### SECTION 14 - REMARKS

14A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

### SECTION 15 - EXAMINER'S CERTIFICATION AND SIGNATURE

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

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

15A. Examiner's signature:

15B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

15C. Examiner's area of practice/specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

15D. Date signed:

15E. Examiner's phone/fax numbers:

15F. National Provider Identifier (NPI) number:

15G. Medical license number and state:

15H. Examiner's address: