

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 I - 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 conditions 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 the remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis or an approximate date determined through record review or reported history.

1B. Select diagnoses associated with the claimed condition(s) (check all that apply):

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

	Side affected:			ICD Code:	Date of diagnosis:	
	Right	Left	Both		Right:	Left:
<input type="checkbox"/> Osteoarthritis, hip	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Hip joint replacement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Hip joint resurfacing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Trochanteric pain syndrome (includes trochanteric bursitis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Femoral acetabular impingement syndrome (includes labral tears)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Iliopsoas tendinitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Femoral neck stress fracture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Avascular necrosis, hip	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Ankylosis of hip joint	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Degenerative arthritis, other than posttraumatic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Arthritis, gonorrheal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Arthritis, pneumococcic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Arthritis, streptococcic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Arthritis, syphilitic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Arthritis, rheumatoid (multi-joints)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Post-traumatic arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Arthritis, typhoid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Other specified forms of arthropathy (excluding gout) (specify)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Osteoporosis, residuals of	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Osteomalacia, residuals of	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Bones, neoplasm, benign	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Osteitis deformans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Gout	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Bursitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Myositis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Heterotopic ossification	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Tendinopathy (select one if known)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Tendinitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Tendinosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		
<input type="checkbox"/> Tenosynovitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____		

Inflammatory other types (specify)

Right    Left    Both   \_\_\_\_\_   Right:   Left:

Other (specify)

Other diagnosis #1

Side affected:    Right    Left    Both

ICD Code:                      Date of diagnosis:                      Right:                      Left:

Other diagnosis #2

Side affected:    Right    Left    Both

ICD Code:                      Date of diagnosis:                      Right:                      Left:

Other diagnosis #3

Side affected:    Right    Left    Both

ICD Code:                      Date of diagnosis:                      Right:                      Left:

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

## SECTION II - MEDICAL HISTORY

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

2B. Does the Veteran report flare-ups of the hip or thigh?                       Yes                       No

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

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.

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

There are several separate parameters requested for describing function of a joint. The question "Does this ROM contribute to a functional loss?" asks if there is a functional loss that can be ascribed to any documented loss of range of motion; and, unlike later questions, does not take into account the numerous other 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.

<p>Right hip</p> <p>3A. Initial ROM measurements</p> <p> <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         </p> <p>If "Unable to test" or "Not indicated" please explain:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div> <p>If ROM is outside of "normal" range, but is normal for the Veteran (for reason other than a hip/thigh condition, such as age, body habitus, neurologic disease), please describe:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div> <p>If abnormal, does the range of motion itself contribute to a functional loss?</p> <p> <input type="radio"/> Yes      <input type="radio"/> No         </p> <p>(if yes, please explain)</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>	<p>Left hip</p> <p>3A. Initial ROM measurements</p> <p> <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         </p> <p>If "Unable to test" or "Not indicated" please explain:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div> <p>If ROM is outside of "normal" range, but is normal for the Veteran (for reason other than a hip/thigh condition, such as age, body habitus, neurologic disease), please describe:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div> <p>If abnormal, does the range of motion itself contribute to a functional loss?</p> <p> <input type="radio"/> Yes      <input type="radio"/> No         </p> <p>(if yes, please explain)</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>
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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).

<p>Can testing be performed?      <input type="radio"/> Yes      <input type="radio"/> No</p> <p>If no, provide an explanation:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div> <p>If this is the unclaimed joint, is it:      <input type="radio"/> Damaged      <input type="radio"/> Undamaged</p> <p>If undamaged, range of motion testing must be conducted.</p>	<p>Can testing be performed?      <input type="radio"/> Yes      <input type="radio"/> No</p> <p>If no, provide an explanation:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div> <p>If this is the unclaimed joint, is it:      <input type="radio"/> Damaged      <input type="radio"/> Undamaged</p> <p>If undamaged, range of motion testing must be conducted.</p>
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If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.

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

Does a limitation in passive adduction prevent the Veteran from crossing his/her legs?

Yes  No

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

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

Does a limitation in passive adduction prevent the Veteran from crossing his/her legs?

Yes  No

Is there evidence of pain?  Yes  No

If yes 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 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).

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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).

<p><b>3B. Observed repetitive use ROM</b></p> <p>Is the Veteran able to perform repetitive-use testing with at least three repetitions?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>If no, please explain:</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div> <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> <table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">Flexion endpoint (125 degrees)</td> <td style="width: 30%;">degrees</td> </tr> <tr> <td>Extension endpoint (30 degrees)</td> <td>degrees</td> </tr> <tr> <td>Abduction endpoint (45 degrees)</td> <td>degrees</td> </tr> <tr> <td>Adduction endpoint (25 degrees)</td> <td>degrees</td> </tr> <tr> <td>External rotation endpoint (60 degrees)</td> <td>degrees</td> </tr> <tr> <td>Internal rotation endpoint (40 degrees)</td> <td>degrees</td> </tr> </table> <p>Does limitation in adduction after observed repetitive use prevent the Veteran from crossing his/her legs?</p> <p><input type="radio"/> Yes    <input type="radio"/> 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>	Flexion endpoint (125 degrees)	degrees	Extension endpoint (30 degrees)	degrees	Abduction endpoint (45 degrees)	degrees	Adduction endpoint (25 degrees)	degrees	External rotation endpoint (60 degrees)	degrees	Internal rotation endpoint (40 degrees)	degrees	<p><b>3B. Observed repetitive use ROM</b></p> <p>Is the Veteran able to perform repetitive-use testing with at least three repetitions?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>If no, please explain:</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div> <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> <table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">Flexion endpoint (125 degrees)</td> <td style="width: 30%;">degrees</td> </tr> <tr> <td>Extension endpoint (30 degrees)</td> <td>degrees</td> </tr> <tr> <td>Abduction endpoint (45 degrees)</td> <td>degrees</td> </tr> <tr> <td>Adduction endpoint (25 degrees)</td> <td>degrees</td> </tr> <tr> <td>External rotation endpoint (60 degrees)</td> <td>degrees</td> </tr> <tr> <td>Internal rotation endpoint (40 degrees)</td> <td>degrees</td> </tr> </table> <p>Does limitation in adduction after observed repetitive use prevent the Veteran from crossing his/her legs?</p> <p><input type="radio"/> Yes    <input type="radio"/> 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>	Flexion endpoint (125 degrees)	degrees	Extension endpoint (30 degrees)	degrees	Abduction endpoint (45 degrees)	degrees	Adduction endpoint (25 degrees)	degrees	External rotation endpoint (60 degrees)	degrees	Internal rotation endpoint (40 degrees)	degrees
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<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="radio"/> Yes    <input type="radio"/> 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> <table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">Flexion endpoint (125 degrees)</td> <td style="width: 30%;">degrees</td> </tr> <tr> <td>Extension endpoint (30 degrees)</td> <td>degrees</td> </tr> <tr> <td>Abduction endpoint (45 degrees)</td> <td>degrees</td> </tr> <tr> <td>Adduction endpoint (25 degrees)</td> <td>degrees</td> </tr> <tr> <td>External rotation endpoint (60 degrees)</td> <td>degrees</td> </tr> <tr> <td>Internal rotation endpoint (40 degrees)</td> <td>degrees</td> </tr> </table>	Flexion endpoint (125 degrees)	degrees	Extension endpoint (30 degrees)	degrees	Abduction endpoint (45 degrees)	degrees	Adduction endpoint (25 degrees)	degrees	External rotation endpoint (60 degrees)	degrees	Internal rotation endpoint (40 degrees)	degrees	<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="radio"/> Yes    <input type="radio"/> 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> <table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">Flexion endpoint (125 degrees)</td> <td style="width: 30%;">degrees</td> </tr> <tr> <td>Extension endpoint (30 degrees)</td> <td>degrees</td> </tr> <tr> <td>Abduction endpoint (45 degrees)</td> <td>degrees</td> </tr> <tr> <td>Adduction endpoint (25 degrees)</td> <td>degrees</td> </tr> <tr> <td>External rotation endpoint (60 degrees)</td> <td>degrees</td> </tr> <tr> <td>Internal rotation endpoint (40 degrees)</td> <td>degrees</td> </tr> </table>	Flexion endpoint (125 degrees)	degrees	Extension endpoint (30 degrees)	degrees	Abduction endpoint (45 degrees)	degrees	Adduction endpoint (25 degrees)	degrees	External rotation endpoint (60 degrees)	degrees	Internal rotation endpoint (40 degrees)	degrees
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<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>Does limitation in adduction after repeated use over time prevent the Veteran from crossing his/her legs?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</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>Does limitation in adduction after repeated use over time prevent the Veteran from crossing his/her legs?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p>
<p>3D. Flare-ups</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="radio"/> Yes    <input type="radio"/> 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>Flexion endpoint (125 degrees)                      degrees</p> <p>Extension endpoint (30 degrees)                      degrees</p> <p>Abduction endpoint (45 degrees)                      degrees</p> <p>Adduction endpoint (25 degrees)                      degrees</p> <p>External rotation endpoint (60 degrees)                      degrees</p> <p>Internal rotation endpoint (40 degrees)                      degrees</p>	<p>3D. Flare-ups</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="radio"/> Yes    <input type="radio"/> 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>Flexion endpoint (125 degrees)                      degrees</p> <p>Extension endpoint (30 degrees)                      degrees</p> <p>Abduction endpoint (45 degrees)                      degrees</p> <p>Adduction endpoint (25 degrees)                      degrees</p> <p>External rotation endpoint (60 degrees)                      degrees</p> <p>Internal rotation endpoint (40 degrees)                      degrees</p>
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Does limitation in adduction during flare-ups prevent the Veteran from crossing his/her legs? <input type="radio"/> Yes <input type="radio"/> No	Does limitation in adduction during flare-ups prevent the Veteran from crossing his/her legs? <input type="radio"/> Yes <input type="radio"/> No
3E. Additional factors contributing to disability	3E. Additional factors contributing to disability
In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:	In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:
<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:	<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:
Please describe additional contributing factors of disability: <div style="border: 1px solid black; height: 80px; width: 100%;"></div>	Please describe additional contributing factors of disability: <div style="border: 1px solid black; height: 80px; width: 100%;"></div>

**SECTION IV - MUSCLE ATROPHY**

<b>RIGHT HIP</b>	<b>LEFT HIP</b>
4A. Does the Veteran have muscle atrophy? <input type="radio"/> Yes <input type="radio"/> No	4A. Does the Veteran have muscle atrophy? <input type="radio"/> Yes <input type="radio"/> No
4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section? <input type="radio"/> Yes <input type="radio"/> No    If no, provide rationale:	4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section? <input type="radio"/> Yes <input type="radio"/> No    If no, provide rationale:
<div style="border: 1px solid black; height: 60px; width: 100%;"></div>	<div style="border: 1px solid black; height: 60px; width: 100%;"></div>
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.	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.
<input type="checkbox"/> Right lower extremity (specify location of measurement such as "10cm above or below the hip"):  Circumference of more normal side:                      cm Circumference of atrophied side:                              cm	<input type="checkbox"/> Left lower extremity (specify location of measurement such as "10cm above or below the hip"):  Circumference of more normal side:                      cm Circumference of atrophied side:                              cm

**SECTION V - ANKYLOSIS**

<b>RIGHT HIP</b>	<b>LEFT HIP</b>
Note: Ankylosis is the immobilization of a joint due to disease, injury, or surgical procedure.	
5A. Is there ankylosis of the hip and/or thigh? <input type="radio"/> Yes <input type="radio"/> No	5A. Is there ankylosis of the hip and/or thigh? <input type="radio"/> Yes <input type="radio"/> No
If yes, indicate the severity of ankylosis: <input type="checkbox"/> Unfavorable, extremely unfavorable ankylosis, foot not reaching ground, crutches needed <input type="checkbox"/> Intermediate, between favorable and unfavorable <input type="checkbox"/> Favorable, in flexion at an angle between 20 and 40 degrees, and slight abduction or adduction	If yes, indicate the severity of ankylosis: <input type="checkbox"/> Unfavorable, extremely unfavorable ankylosis, foot not reaching ground, crutches needed <input type="checkbox"/> Intermediate, between favorable and unfavorable <input type="checkbox"/> Favorable, in flexion at an angle between 20 and 40 degrees, and slight abduction or adduction

**SECTION VI - FEMUR OR FLAIL HIP JOINT IMPAIRMENT**

RIGHT HIP	LEFT HIP
<p>Note: If impairment of the femur causes an associated knee disability, please complete the additional appropriate questionnaire.</p>	
<p>6A. Does the Veteran have malunion or non union of femur, flail hip joint or leg length discrepancy?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p><input type="checkbox"/> Fracture of shaft or neck (anatomical), with nonunion with loose motion (spiral or oblique fracture)</p> <p><input type="checkbox"/> Fracture of shaft or neck (anatomical), resulting in nonunion without loose motion; weight-bearing preserved with aid of brace</p> <p><input type="checkbox"/> Fracture of surgical neck with false joint</p> <p><input type="checkbox"/> Malunion of the femur</p> <p><input type="checkbox"/> Flail hip joint</p> <p><input type="checkbox"/> Leg length discrepancy (shortening of any bones of the lower extremity) (If checked, provide length of each lower extremity in inches (to the nearest 1/4 inch) or centimeters measuring from the anterior superior iliac spine to the internal malleolus of the tibia.)</p> <p>Measurements:    Right leg:                      <input type="radio"/> cm    <input type="radio"/> inch</p> <p>For any leg length discrepancy, please describe the relationship to the conditions listed in the diagnosis section above:</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>	<p>6A. Does the Veteran have malunion or non union of femur, flail hip joint or leg length discrepancy?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p><input type="checkbox"/> Fracture of shaft or neck (anatomical), with nonunion with loose motion (spiral or oblique fracture)</p> <p><input type="checkbox"/> Fracture of shaft or neck (anatomical), resulting in nonunion without loose motion; weight-bearing preserved with aid of brace</p> <p><input type="checkbox"/> Fracture of surgical neck with false joint</p> <p><input type="checkbox"/> Malunion of the femur</p> <p><input type="checkbox"/> Flail hip joint</p> <p><input type="checkbox"/> Leg length discrepancy (shortening of any bones of the lower extremity) (If checked, provide length of each lower extremity in inches (to the nearest 1/4 inch) or centimeters measuring from the anterior superior iliac spine to the internal malleolus of the tibia.)</p> <p>Measurements:    Left leg:                                      <input type="radio"/> cm    <input type="radio"/> inch</p> <p>For any leg length discrepancy, please describe the relationship to the conditions listed in the diagnosis section above:</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>

**SECTION VII - SURGICAL PROCEDURES**

RIGHT HIP	LEFT HIP
<p>7A. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):</p> <p><input type="checkbox"/> No surgery</p> <p><input type="checkbox"/> Hip joint resurfacing                      Date of surgery:</p> <p><input type="checkbox"/> Total hip joint replacement              Date of surgery:</p> <p>    Total hip joint replacement residuals:</p> <p>    <input type="checkbox"/> None</p> <p>    <input type="checkbox"/> Moderately severe residuals of weakness, pain or limitation of motion</p> <p>    <input type="checkbox"/> Markedly severe residuals of weakness, pain or limitation of motion following implantation of prosthesis</p> <p>    <input type="checkbox"/> Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches</p> <p>    <input type="checkbox"/> Other, describe:</p> <p><input type="checkbox"/> Arthroscopic ligament repair              Date of surgery:</p> <p><input type="checkbox"/> Other surgery not described (specify below):              Date of surgery:</p> <p>    Type of surgery:</p>	<p>7A. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):</p> <p><input type="checkbox"/> No surgery</p> <p><input type="checkbox"/> Hip joint resurfacing                      Date of surgery:</p> <p><input type="checkbox"/> Total hip joint replacement              Date of surgery:</p> <p>    Total hip joint replacement residuals:</p> <p>    <input type="checkbox"/> None</p> <p>    <input type="checkbox"/> Moderately severe residuals of weakness, pain or limitation of motion</p> <p>    <input type="checkbox"/> Markedly severe residuals of weakness, pain or limitation of motion following implantation of prosthesis</p> <p>    <input type="checkbox"/> Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches</p> <p>    <input type="checkbox"/> Other, describe:</p> <p><input type="checkbox"/> Arthroscopic ligament repair              Date of surgery:</p> <p><input type="checkbox"/> Other surgery not described (specify below):              Date of surgery:</p> <p>    Type of surgery:</p>

Residuals of arthroscopic or other hip surgery

Describe residuals:

Residuals of arthroscopic or other hip surgery

Describe residuals:

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

8A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the diagnosis section above?

Yes     No    If yes, describe (brief summary)

8B. Does the Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis section above?

Yes     No    If yes, also complete the appropriate dermatological questionnaire.

**SECTION IX - ASSISTIVE DEVICES**

9A. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible?

Yes     No    If yes, identify 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 for ambulation   | Frequency of use: | <input type="radio"/> Occasional | <input type="radio"/> Regular | <input type="radio"/> Constant |
| <input type="checkbox"/> Crutches               | 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, describe: _____ | Frequency of use: | <input type="radio"/> Occasional | <input type="radio"/> Regular | <input type="radio"/> Constant |

9B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

**SECTION X - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES**

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

10A. Due to the Veterans hip or thigh condition(s), is there functional impairment of an extremity such that no effective functions remain other than that which would be equally well served by an amputation with prosthesis (functions of the lower extremity include balance and propulsion, etc.)?

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

If yes, indicate extremities for which this applies:  Right lower  Left lower

10B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

**SECTION XI - DIAGNOSTIC TESTING**

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

11A. Have imaging studies been performed in conjunction with this examination?  Yes  No

11B. If yes, is degenerative or post-traumatic arthritis documented?  Yes  No

Indicate side.  Right  Left  Both

11C. If yes provide type of test or procedure, date and results (brief summary):

11D. Are there any other significant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

Yes  No

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

11E. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

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**SECTION XII - FUNCTIONAL IMPACT**

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

12A. Regardless of the Veteran's current employment status, do the 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:

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**SECTION XIII - REMARKS**

13A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

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**SECTION XIV - 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.

14A. Examiner's signature: _____		14B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C): _____	
14C. Examiner's Area of Practice/Specialty (e.g. Cardiology, 9Orthopedics, Psychology/Psychiatry, General Practice): _____		14D. Date Signed: _____	
14E. Examiner's phone/fax numbers: _____	14F. National Provider Identifier (NPI) number: _____	14G. Medical license number and state: _____	
14H. Examiner's address: _____ _____			