

Name of Claimant/Veteran:	Claimant/Veteran's Social Security Number:	Date of Examination:
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IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) *WILL NOT PAY OR REIMBURSE* ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM.

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

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

Veteran/Claimant

Other, please describe:

Are you a VA Healthcare provider? Yes No

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

Was the Veteran examined in person? Yes No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

No records were reviewed

Records reviewed

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

SECTION I - DIAGNOSIS

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

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

	Side affected:			ICD Code:	Date of diagnosis:	
	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	_____	Right: _____	Left: _____
<input type="checkbox"/> Lateral collateral ligament sprain (chronic/recurrent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Deltoid ligament sprain (chronic/recurrent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Osteochondritis dissecans to include osteochondral fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Impingement (anterior/posterior (or trigonum syndrome)/anterolateral)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Tendonitis (Achilles/peroneal/posterior tibial)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Retrocalcaneal bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Achilles' tendon rupture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Avascular necrosis, talus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Ankle joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Ankylosis of ankle, subtalar or tarsal joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Medial tibial stress syndrome (MTSS), or shin splints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Degenerative arthritis, other than post-traumatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, gonorrheal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, pneumococcic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, streptococcic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, syphilitic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, rheumatoid (multi-joints)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, post-traumatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Arthritis, typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Other specified forms of arthropathy (excluding gout):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Osteoporosis, residuals of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Osteomalacia, residuals of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Bones, neoplasm, benign	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Bones, neoplasm, malignant, primary or secondary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Osteitis deformans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Myositis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Heterotopic ossification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Tendinopathy (select one if known)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Tendinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Tendinosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____
<input type="checkbox"/> Tenosynovitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Right: _____	Left: _____

SECTION I - DIAGNOSIS (continued)

<input type="checkbox"/> Other (specify):	Side affected:	ICD Code:	Date of diagnosis:
Other diagnosis #1:	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
Other diagnosis #2:	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
Other diagnosis #3:	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____

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

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's ankle condition (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 III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION (continued)

RIGHT ANKLE	LEFT ANKLE
<p>If noted on examination, which ROM exhibited pain (select all that apply):</p> <p><input type="checkbox"/> Plantar flexion <input type="checkbox"/> Dorsiflexion</p> <p>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.</p> <p>_____ Plantar flexion degree endpoint (if different than above)</p> <p>_____ Dorsiflexion degree endpoint (if different than above)</p> <p>Passive Range of Motion - Perform passive range of motion and provide the ROM values.</p> <p>Plantar flexion endpoint (45 degrees): _____ degrees <input type="checkbox"/> Same as active ROM</p> <p>Dorsiflexion endpoint (20 degrees): _____ degrees <input type="checkbox"/> Same as active ROM</p> <p>If noted on examination, which passive ROM exhibited pain (select all that apply):</p> <p><input type="checkbox"/> Plantar flexion <input type="checkbox"/> Dorsiflexion</p> <p>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.</p> <p>_____ Plantar flexion degree endpoint (if different than above)</p> <p>_____ Dorsiflexion degree endpoint (if different than above)</p> <p>Is there evidence of pain? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check all that apply.</p> <p><input type="checkbox"/> Weight-bearing <input type="checkbox"/> Nonweight-bearing</p> <p><input type="checkbox"/> Active motion <input type="checkbox"/> Passive motion <input type="checkbox"/> On rest/non-movement</p> <p><input type="checkbox"/> Causes functional loss (if checked describe in the comments box below)</p> <p><input type="checkbox"/> Does not result in/cause functional loss</p> <p>Comments:</p> <p>Is there objective evidence of crepitus? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please explain. Include location, severity, and relationship to condition(s).</p>	<p>If noted on examination, which ROM exhibited pain (select all that apply):</p> <p><input type="checkbox"/> Plantar flexion <input type="checkbox"/> Dorsiflexion</p> <p>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.</p> <p>_____ Plantar flexion degree endpoint (if different than above)</p> <p>_____ Dorsiflexion degree endpoint (if different than above)</p> <p>Passive Range of Motion - Perform passive range of motion and provide the ROM values.</p> <p>Plantar flexion endpoint (45 degrees): _____ degrees <input type="checkbox"/> Same as active ROM</p> <p>Dorsiflexion endpoint (20 degrees): _____ degrees <input type="checkbox"/> Same as active ROM</p> <p>If noted on examination, which passive ROM exhibited pain (select all that apply):</p> <p><input type="checkbox"/> Plantar flexion <input type="checkbox"/> Dorsiflexion</p> <p>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.</p> <p>_____ Plantar flexion degree endpoint (if different than above)</p> <p>_____ Dorsiflexion degree endpoint (if different than above)</p> <p>Is there evidence of pain? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check all that apply.</p> <p><input type="checkbox"/> Weight-bearing <input type="checkbox"/> Nonweight-bearing</p> <p><input type="checkbox"/> Active motion <input type="checkbox"/> Passive motion <input type="checkbox"/> On rest/non-movement</p> <p><input type="checkbox"/> Causes functional loss (if checked describe in the comments box below)</p> <p><input type="checkbox"/> Does not result in/cause functional loss</p> <p>Comments:</p> <p>Is there objective evidence of crepitus? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please explain. Include location, severity, and relationship to condition(s).</p>

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

RIGHT ANKLE	LEFT ANKLE
<p>3B. Observed repetitive use ROM</p> <p>Is the Veteran able to perform repetitive-use testing with at least three repetitions?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain:</p> <p>Is there additional loss of function or range of motion after three repetitions?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> 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>3B. Observed repetitive use ROM</p> <p>Is the Veteran able to perform repetitive-use testing with at least three repetitions?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain:</p> <p>Is there additional loss of function or range of motion after three repetitions?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> 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>

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>3C. Repeated use over time</p> <p>Is the Veteran being examined immediately after repeated use over time?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> 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>	<p>3C. Repeated use over time</p> <p>Is the Veteran being examined immediately after repeated use over time?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> 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>
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SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION (continued)

RIGHT ANKLE	LEFT ANKLE
<p>3D. Flare-ups</p> <p>Is the examination being conducted during a flare-up?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> 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>	<p>3D. Flare-ups</p> <p>Is the examination being conducted during a flare-up?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> 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>
<p>3E. Additional factors contributing to disability</p> <p>In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:</p> <p><input type="checkbox"/> None <input type="checkbox"/> Interference with sitting</p> <p><input type="checkbox"/> Interference with standing <input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Disturbance of locomotion <input type="checkbox"/> Deformity</p> <p><input type="checkbox"/> Less movement than normal <input type="checkbox"/> More movement than normal</p> <p><input type="checkbox"/> Weakened movement <input type="checkbox"/> Atrophy of disuse</p> <p><input type="checkbox"/> Instability of station</p> <p><input type="checkbox"/> Other, describe:</p> <p>Please describe additional contributing factors of disability:</p>	<p>3E. Additional factors contributing to disability</p> <p>In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:</p> <p><input type="checkbox"/> None <input type="checkbox"/> Interference with sitting</p> <p><input type="checkbox"/> Interference with standing <input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Disturbance of locomotion <input type="checkbox"/> Deformity</p> <p><input type="checkbox"/> Less movement than normal <input type="checkbox"/> More movement than normal</p> <p><input type="checkbox"/> Weakened movement <input type="checkbox"/> Atrophy of disuse</p> <p><input type="checkbox"/> Instability of station</p> <p><input type="checkbox"/> Other, describe:</p> <p>Please describe additional contributing factors of disability:</p>

SECTION VI - JOINT STABILITY

RIGHT ANKLE	LEFT ANKLE
<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="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to test</p> <p>Talar Tilt Test: Is there asymmetric or excessive motion?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to test</p> <p>If unable to test, please explain why:</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="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to test</p> <p>Talar Tilt Test: Is there asymmetric or excessive motion?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to test</p> <p>If unable to test, please explain why:</p>
<p>6B. If unable to test, is ankle instability suspected? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p>	<p>6B. If unable to test, is ankle instability suspected? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p>

SECTION VII - ADDITIONAL COMMENTS

<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 talectomy (astragalectomy)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> 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:</p> <p><input type="checkbox"/> Achilles tendonitis or Achilles tendon rupture</p> <p>Describe current symptoms:</p> <p><input type="checkbox"/> Malunion of calcaneus (os calcis) or talus (astragalus)</p> <p>Indicate severity:</p> <p><input type="checkbox"/> Moderate deformity</p> <p><input type="checkbox"/> Marked deformity</p> <p><input type="checkbox"/> "Shin Splints" (medial tibial stress syndrome - MTSS)</p> <p>Indicate all treatment and symptoms below:</p> <p><input type="checkbox"/> Treatment for less than 12 consecutive months</p> <p><input type="checkbox"/> Unresponsive to shoe orthotics or other conservative treatment</p> <p><input type="checkbox"/> Requiring treatment for 12 consecutive months or more</p> <p><input type="checkbox"/> Responsive to surgery</p> <p><input type="checkbox"/> Unresponsive to surgery</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 talectomy (astragalectomy)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> 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:</p> <p><input type="checkbox"/> Achilles tendonitis or Achilles tendon rupture</p> <p>Describe current symptoms:</p> <p><input type="checkbox"/> Malunion of calcaneus (os calcis) or talus (astragalus)</p> <p>Indicate severity:</p> <p><input type="checkbox"/> Moderate deformity</p> <p><input type="checkbox"/> Marked deformity</p> <p><input type="checkbox"/> "Shin Splints" (medial tibial stress syndrome - MTSS)</p> <p>Indicate all treatment and symptoms below:</p> <p><input type="checkbox"/> Treatment for less than 12 consecutive months</p> <p><input type="checkbox"/> Unresponsive to shoe orthotics or other conservative treatment</p> <p><input type="checkbox"/> Requiring treatment for 12 consecutive months or more</p> <p><input type="checkbox"/> Responsive to surgery</p> <p><input type="checkbox"/> Unresponsive to surgery</p>
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SECTION VII - ADDITIONAL COMMENTS (continued)

RIGHT ANKLE

LEFT ANKLE

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:

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 VIII - 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: _____
- Residuals of arthroscopic or other ankle surgery
Describe residuals:

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: _____
- Residuals of arthroscopic or other ankle surgery
Describe residuals:

SECTION IX - 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, complete appropriate dermatological questionnaire.

SECTION X - 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 assistive devices used (check all that apply and indicate frequency):

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

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

SECTION XI - 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 XII - 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 imaging studies been performed in conjunction with this examination?

Yes No

12B. If yes, is degenerative or post-traumatic arthritis documented?

Yes No

Indicate side: Right Left Both

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

12D. 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):

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

SECTION XIII - 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 XIV - REMARKS

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

SECTION XV - EXAMINER'S CERTIFICATION AND SIGNATURE

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

15A. Examiner's signature

15B. Examiner's printed name

15C. Date signed

15D. Examiner's phone number

15E. National Provider Identifier (NPI) number

15F. Medical license and state number

15G. Examiner's address