



BONES AND OTHER SKELETAL CONDITIONS
DISABILITY BENEFITS QUESTIONNAIRE

Name of Claimant/Veteran:
Claimant/Veteran's Social Security Number:
Date of Examination:

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

Note - The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

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.

DOMINANT HAND

Dominant hand: Right Left Ambidextrous

SECTION I - DIAGNOSIS

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.

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)

Skull fracture Skull loss Costochondritis
Side affected: Right Left Both
ICD Code:
Date of diagnosis: Right: Left:

SECTION I - DIAGNOSIS (continued)

	Side affected:	ICD Code:	Date of diagnosis:
<input type="checkbox"/> Rib fracture	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Rib resection	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Bones, neoplasm, malignant primary or secondary	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Bones, neoplasm, benign	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Coccyx, removal of			Date: _____
<input type="checkbox"/> 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 the bones or other skeletal conditions, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's bone and/or other skeletal condition (brief summary):

SECTION III - SKULL, LOSS OF PART OF, BOTH INNER AND OUTER TABLES

3A. If skull loss or fracture is present, does the Veteran have a brain hernia? Yes No

3B. If skull loss is present, indicate the area of skull loss:

- Area smaller than the size of a 25-cent piece or 0.716 in² (4.619 cm²)
- Area intermediate
- Area larger than size of a 50-cent piece or 1.140 in² (7.355 cm²)

SECTION IV - SPINE AND CHEST

4A. Does the Veteran have costochondritis? Yes No If yes, describe below:

4B. Has the Veteran undergone rib removal or resection? Yes No If yes, please specify:

- Rib removal (complete the following):
 - More than six
 - Five or six
 - Three or four
 - Two
 - One
- Resection of two or more ribs without regeneration

4C. Has the Veteran undergone removal of the coccyx? Yes No If yes, please specify:

- Partial or complete, with painful residuals
- Without painful residuals (including no residuals)

SECTION V - TUMORS AND NEOPLASMS

5A. Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the diagnosis section? Yes No If yes, also complete questions 5B through 5E.

5B. Is the neoplasm:

- Benign
- Malignant (if malignant complete the following):
 - Primary Secondary (metastatic) If secondary, indicate the primary site, if known: _____

5C. Indicate the type of treatment the Veteran is currently undergoing or has completed (check all that apply):

- Treatment completed; currently in watchful waiting status
- Surgery
 - Date of surgery: _____
 - Type of surgery and description: _____
- Radiation therapy
 - Date of most recent treatment: _____
 - Date of completion of treatment or anticipated date of completion: _____
- Antineoplastic chemotherapy
 - Date of most recent treatment: _____
 - Date of completion of treatment or anticipated date of completion: _____
- Other therapeutic procedure
 - Date of most recent procedure: _____
 - Type of procedure and description: _____
- Other therapeutic treatment
 - Date of most recent treatment: _____
 - Type of treatment and description: _____
 - Date of completion of treatment or anticipated date of completion: _____

5D. Does the Veteran currently have any residual conditions or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above? Yes No If yes, list residual conditions, complications (brief summary), and also complete the appropriate questionnaire:

5E. If there are additional malignant neoplasms or metastases related to any of the diagnoses in the diagnosis section, describe using the format in 5C:

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

6A. 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):

6B. 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 VII - ASSISTIVE DEVICES

7A. 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="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"/> Crutch(es) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Cane(s) | 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, describe: _____ | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |

7B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

SECTION VIII - 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.

8A. Due to the Veteran's bones or other skeletal 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 upper extremity include grasping, manipulation, etc., while functions of the lower extremity include balance, 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 upper Left upper Right lower Left lower

8B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

SECTION IX - DIAGNOSTIC TESTING

9A. Have imaging studies been performed in conjunction with this examination? Yes No If yes, indicate tests performed, dates, and results:

- | | | |
|---|---------------------|----------------|
| <input type="checkbox"/> Bone scan | Date of test: _____ | Results: _____ |
| <input type="checkbox"/> X-ray | Date of test: _____ | Results: _____ |
| <input type="checkbox"/> MRI | Date of test: _____ | Results: _____ |
| <input type="checkbox"/> Bone biopsy and/or culture | Date of test: _____ | Results: _____ |
| <input type="checkbox"/> Other, describe: _____ | Date of test: _____ | Results: _____ |

9B. 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):

9C. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

SECTION X - 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.

10A. 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 XI - REMARKS

11A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION XII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

12A. Examiner's signature:

12B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

12C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

12D. Date Signed:

12E. Examiner's phone/fax numbers:

12F. National Provider Identifier (NPI) number:

12G. Medical license number and state:

12H. Examiner's address: