OMB Approved No. 2900-XXXX
Respondent Burden: 15 minutes

Department of Veterans Affairs

FOOT MISCELLANEOUS (OTHER THAN FLATFOOT/PES PLANUS) DISABILITY BENEFITS QUESTIONNAIRE

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

NOTE TO PHYSICIAN - Your patient 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.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN HAVE A FOOT CONDITION *(OTHER THAN FLATFOOT)*?

☐ YES ☐ NO *(If "Yes," complete Item 1C) (If "No," complete Item 1B)*

1B. PROVIDE RATIONALE *(e.g. veteran does not currently have any known foot condition(s))*

1C. INDICATE DIAGNOSIS/ES *(Check all that apply)* AND COMPLETE THE APPROPRIATE SECTION(S) OF THE FORM

☐ MORTON'S NEUROMA	ICD CODE -	DATE OF DIAGNOSIS -
☐ METATARSALGIA	ICD CODE -	DATE OF DIAGNOSIS -
☐ HAMMER TOES	ICD CODE -	DATE OF DIAGNOSIS -
☐ HALLUX VALGUS	ICD CODE -	DATE OF DIAGNOSIS -
☐ HALLUX RIGIDUS	ICD CODE -	DATE OF DIAGNOSIS -
☐ CLAW FOOT *(PES CAVUS)*	ICD CODE -	DATE OF DIAGNOSIS -
☐ MALUNION/NONUNION OF TARSAL/METATARSAL BONES	ICD CODE -	DATE OF DIAGNOSIS -
☐ FOOT INJURIES *(specify)* _____ _____	ICD CODE -	DATE OF DIAGNOSIS -
☐ OTHER FOOT CONDITIONS *(specify)* _____ _____	ICD CODE -	DATE OF DIAGNOSIS -

NOTE - If the veteran has flatfoot, also complete the VA Form 21-0960M-5, Flatfoot (Pes Planus) Disability Benefits Questionnaire.

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S CURRENT FOOT CONDITION(S) *(brief summary)*

SECTION III - MORTON'S NEUROMA (Morton's disease) AND /OR METATARSALGIA

3A. DOES THE VETERAN HAVE MORTON'S NEUROMA?

☐ YES ☐ NO

If "Yes," indicate affected side(s) ☐ Right ☐ Left ☐ Both

3B. DOES THE VETERAN HAVE METATARSALGIA?

☐ YES ☐ NO

If "Yes," indicate affected side(s) ☐ Right ☐ Left ☐ Both

SECTION IV - HAMMER TOE

4. DOES THE VETERAN HAVE HAMMER TOE(S)?

☐ YES ☐ NO

If "Yes," indicate which toes are affected on each side?

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

SECTION V - HALLUX VALGUS

5A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER HAD HALLUX VALGUS?

☐ YES ☐ NO

If "Yes," indicate severity: *(check all that apply))*

☐ Mild or moderate symptoms

Indicate side affected: ☐ Right ☐ Left ☐ Both

☐ Severe, with function equivalent to amputation of great toe

Indicate side affected: ☐ Right ☐ Left ☐ Both

SECTION V - HALLUX VALGUS *(Continued)*

5B. HAS THE VETERAN HAD SURGERY FOR HALLUX VALGUS?

☐ YES ☐ NO

If "Yes," indicate type of surgery and side

☐ Resection of metatarsal head

Date of surgery: _____

Side affected: ☐ Right ☐ Left ☐ Both

☐ Metatarsal osteotomy/metatarsal head osteotomy *(equivalent to metatarsal head resection)*

Date of surgery: _____

Side affected: ☐ Right ☐ Left ☐ Both

☐ Other surgery for hallux valgus, describe: _____

Date of surgery: _____

Side affected: ☐ Right ☐ Left ☐ Both

SECTION VI - HALLUX RIGIDUS

6. DOES THE VETERAN HAVE HALLUX RIGIDUS?

☐ YES ☐ NO

If "Yes," indicate severity: *(check all that apply)*

☐ Mild or moderate symptoms

Side affected: ☐ Right ☐ Left ☐ Both

☐ Severe, with function equivalent to amputation of great toe

Side affected: ☐ Right ☐ Left ☐ Both

SECTION VII - PES CAVUS (CLAW FOOT)

7. DOES THE VETERAN HAVE ACQUIRED CLAW FOOT *(PES CAVUS)*?

☐ YES ☐ NO

If "Yes," complete the Items 7A through 7D

A. Toes *(check all that apply)*

☐ Great toe dorsiflexed	☐ Right	☐ Left	☐ Both
☐ All toes tending to dorsiflexion	☐ Right	☐ Left	☐ Both
☐ All toes hammer toes	☐ Right	☐ Left	☐ Both
☐ None of the above	☐ Right	☐ Left	☐ Both

B. Pain and tenderness *(check all that apply)*

☐ Definite tenderness under metatarsal heads	☐ Right	☐ Left	☐ Both
☐ Marked tenderness under metatarsal heads	☐ Right	☐ Left	☐ Both
☐ Very painful callosities	☐ Right	☐ Left	☐ Both
☐ None of the above	☐ Right	☐ Left	☐ Both

C. Effect on plantar fascia *(check all that apply)*

☐ Shortened plantar fascia	☐ Right	☐ Left	☐ Both
☐ Marked contraction of plantar fascia with dropped forefoot	☐ Right	☐ Left	☐ Both
☐ None of the above	☐ Right	☐ Left	☐ Both

D.Dorsiflexion and varus deformity *(check all that apply)*

☐ Some limitation of dorsiflexion at ankle	☐ Right	☐ Left	☐ Both
☐ Limitation of dorsiflexion at ankle to right angle	☐ Right	☐ Left	☐ Both
☐ Marked varus deformity	☐ Right	☐ Left	☐ Both
☐ None of the above	☐ Right	☐ Left	☐ Both

SECTION VIII - MALUNION OR NONUNION OF TARSAL OR METATARSAL BONES

8. DOES THE VETERAN HAVE MALUNION OR NONUNION OF TARSAL OR METATARSAL BONES?

☐ YES ☐ NO

If "Yes," indicate severity and affected side(s):

☐ Moderate ☐ Right ☐ Left ☐ Both

☐ Moderately severe ☐ Right ☐ Left ☐ Both

☐ Severe ☐ Right ☐ Left ☐ Both

SECTION IX - FOOT INJURIES

9. DOES THE VETERAN HAVE ANY OTHER FOOT INJURIES?

☐ YES ☐ NO If "Yes," describe: _____

If "Yes," indicate severity and affected side(s):

☐ Moderate ☐ Right ☐ Left ☐ Both

☐ Moderately severe ☐ Right ☐ Left ☐ Both

☐ Severe ☐ Right ☐ Left ☐ Both

SECTION X - BILATERAL WEAK FOOT

NOTE - Bilateral weak foot is a symptomatic condition secondary to many constitutional conditions characterized by atrophy of the musculature, disturbed circulation, and weakness.

10. IS THERE EVIDENCE OF BILATERAL WEAK FOOT?

☐ YES ☐ NO

If "Yes," describe: _____

SECTION XI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

11. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

☐ YES ☐ NO

If "Yes," describe: _____

SECTION XII- ASSISTIVE DEVICES AND REMAINING FUNCTION OF THE EXTREMITIES

12A. DOES THE VETERAN USE ANY ASSISTIVE DEVICE(S) AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

☐ YES ☐ NO

If "Yes," identify assistive device(s) used *(check all that apply and indicate frequency):*

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Brace(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutch(es)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

_____

_____

_____

if "Yes," identify and describe each condition(s) causing the need for assistive device(s): _____

12B. DUE TO THE SERVICE-CONNECTED DISABLING 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 for 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 extremity(ies) *(check all extremities for which this applies)*

☐ Right upper ☐ Left upper ☐ Right lower ☐ Left lower

SECTION XIII - DIAGNOSTIC TESTING

NOTE: The diagnosis of arthritis must be confirmed by imaging studies. Once arthritis has been documented, no further imaging studies are indicated, even if arthritis has worsened.

13A. HAVE IMAGING STUDIES OF THE FEET BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

(If "Yes," is arthritis documented in multiple joints of the same foot?)

☐ YES ☐ NO

(If "Yes," indicate foot)

☐ Right ☐ Left ☐ Both

13B. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO

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

SECTION XIV - FUNCTIONAL IMPACT AND REMARKS

14. DOES THE VETERAN'S FOOT CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the veteran's foot conditions providing one or more examples)*

15. REMARKS *(If any)*

SECTION XV - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

16A. PHYSICIAN'S SIGNATURE	16B. PHYSICIAN'S PRINTED NAME	16C. DATE SIGNED

16D. PHYSICIAN'S PHONE NUMBER	16E. PHYSICIAN'S MEDICAL LICENSE NUMBER	16F. PHYSICIAN'S ADDRESS

NOTE - VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the veteran's application.

IMPORTANT - Physician please fax the completed form to _____

(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at www.vba.va.gov/disabilityexams or obtained by calling 1-800-827-1000.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.