

**Department of Veterans Affairs** **KNEE AND LOWER LEG CONDITIONS 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
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**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 KNEE AND/OR LOWER LEG CONDITION?  
 YES  NO (If "Yes," complete Item 1C) (If "No," complete Item 1B)

1B. PROVIDE RATIONALE (e.g. veteran does not currently have any known knee and/or lower leg conditions)

1C. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO KNEE AND/OR LOWER LEG CONDITIONS

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH

1D. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO KNEE AND/OR LOWER LEG CONDITIONS, LIST USING ABOVE FORMAT:

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S KNEE AND/OR LOWER LEG CONDITION(S) (brief summary)

2B. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE KNEE AND/OR LOWER LEG CONDITION(S)?  
 YES  NO

(If "Yes," document the veteran's description of the impact of flare-ups in his or her own words):

**SECTION III - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS**

3. MEASURE ROM WITH A GONIOMETER, ROUNDING EACH MEASUREMENT TO THE NEAREST 5 DEGREES. REPORT INITIAL MEASUREMENTS BELOW:

A. Right knee ROM

Check box at which flexion ends (normal endpoint is 140 degrees):

0  5  10  15  20  25  30  35  40  45  50  55  60  65  70  
 75  80  85  90  95  100  105  110  115  120  125  130  135  140 or greater

Check box at which extension ends:

0 or any degree of hyperextension (check this box if there is no limitation of extension)

Unable to fully extend; extension ends at:

5  10  15  20  25  30  35  40  45 or greater

B. Left knee ROM

Check box at which flexion ends (normal endpoint is 140 degrees):

0  5  10  15  20  25  30  35  40  45  50  55  60  65  70  
 75  80  85  90  95  100  105  110  115  120  125  130  135  140 or greater

Check box at which extension ends:

0 or any degree of hyperextension (check this box if there is no limitation of extension)

Unable to fully extend; extension ends at:

5  10  15  20  25  30  35  40  45 or greater

C. If ROM does not conform to the normal range of motion identified above but is normal for this veteran (for reasons other than a knee and/or leg condition, such as age, body habitus, neurologic disease), explain:

**SECTION IV - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING**

**NOTE:** For VA purposes, repetitive-use testing must also be performed. The VA has determined that 3 repetitions, at minimum, can serve as a representative test for the effect of repetitive use. Following initial ROM assessment, the clinician must perform repetitive-use testing and report post-test measurements.

4A. IS VETERAN ABLE TO PERFORM REPETITIVE-USE TESTING WITH 3 REPETITIONS?

YES  NO

*(If "No," provide reason):*

*(If "No," skip to section 5)*

*(If veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions.)*

4B. RIGHT KNEE POST-TEST ROM

Check box at which post-test flexion ends:

0  5  10  15  20  25  30  35  40  45  50  55  60  65  70  
 75  80  85  90  95  100  105  110  115  120  125  130  135  140 or greater

Check box at which post-test extension ends

0 or any degree of hyperextension *(check this box if there is no limitation of extension)*

Unable to fully extend; extension ends at:

5  10  15  20  25  30  35  40  45 or greater

4C. LEFT KNEE POST-TEST ROM

Check box at which post-test flexion ends:

0  5  10  15  20  25  30  35  40  45  50  55  60  65  70  
 75  80  85  90  95  100  105  110  115  120  125  130  135  140 or greater

Check box at which post-test extension ends

0 or any degree of hyperextension *(check this box if there is no limitation of extension)*

Unable to fully extend; extension ends at:

5  10  15  20  25  30  35  40  45 or greater

**SECTION V - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION IN ROM**

5A. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS AND/OR FUNCTIONAL IMPAIRMENT OF THE KNEE AND LOWER LEG?

YES  NO

5B. DOES THE VETERAN HAVE ADDITIONAL LIMITATION IN ROM OF THE KNEE AND LOWER LEG FOLLOWING REPETITIVE-USE TESTING?

YES  NO

5C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT AND/OR ADDITIONAL LIMITATION OF ROM OF THE KNEE AND LOWER LEG AFTER REPETITIVE USE, INDICATE THE CONTRIBUTING FACTORS OF DISABILITY BELOW *(check all that apply and indicate side affected):*

- NO FUNCTIONAL LOSS FOR RIGHT LOWER EXTREMITY
- NO FUNCTIONAL LOSS FOR LEFT LOWER EXTREMITY
- LESS MOVEMENT THAN NORMAL  Right  Left  Both
- MORE MOVEMENT THAN NORMAL  Right  Left  Both
- WEAKENED MOVEMENT  Right  Left  Both
- EXCESS FATIGABILITY  Right  Left  Both
- INCOORDINATION, IMPAIRED ABILITY TO EXECUTE SKILLED MOVEMENTS SMOOTHLY  Right  Left  Both
- PAIN ON MOVEMENT  Right  Left  Both
- SWELLING  Right  Left  Both
- DEFORMITY  Right  Left  Both
- ATROPHY OF DISUSE  Right  Left  Both
- INSTABILITY OF STATION  Right  Left  Both
- DISTURBANCE OF LOCOMOTION  Right  Left  Both
- INTERFERENCE WITH SITTING, STANDING AND OR WEIGHT-BEARING  Right  Left  Both

**SECTION VI - PAINFUL MOTION, TENDERNESS AND STRENGTH TESTING**

6A. IS THERE OBJECTIVE EVIDENCE OF PAINFUL MOTION FOR EITHER KNEE (*evidenced by visible behavior, such as facial expression, wincing, etc.*)?

YES  NO (*If "Yes," indicate side affected*):  Right  Left  Both

6B. DOES THE VETERAN HAVE TENDERNESS OR PAIN TO PALPATION FOR JOINT LINE AND/OR SOFT TISSUES OF EITHER KNEE?

YES  NO (*If "Yes," indicate side affected*):  Right  Left  Both

6C. STRENGTH TESTING - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

0/5 No muscle movement

1/5 Visible muscle movement, but no joint movement

2/5 No movement against gravity

3/5 No movement against resistance

4/5 Less than normal strength

5/5 Normal strength

Knee extension: Right  5/5  4/5  3/5  2/5  1/5  0/5  
Left  5/5  4/5  3/5  2/5  1/5  0/5

**SECTION VII - JOINT STABILITY TESTS**

7A. ANTERIOR INSTABILITY (*Lachman test*):

Unable to test:  Right  Left  Both

Right:  Normal  1+(0-5 millimeters)  2+(5-10 millimeters)  3+(10-15 millimeters)

Left:  Normal  1+(0-5 millimeters)  2+(5-10 millimeters)  3+(10-15 millimeters)

7B. POSTERIOR INSTABILITY (*Posterior drawer test*):

Unable to test:  Right  Left  Both

Right:  Normal  1+(0-5 millimeters)  2+(5-10 millimeters)  3+(10-15 millimeters)

Left:  Normal  1+(0-5 millimeters)  2+(5-10 millimeters)  3+(10-15 millimeters)

7C. MEDIAL-LATERAL INSTABILITY (*Apply valgus/varus pressure to knee in extension and 30 degrees of flexion*):

Unable to test:  Right  Left  Both

Right:  Normal  1+(0-5 millimeters)  2+(5-10 millimeters)  3+(10-15 millimeters)

Left:  Normal  1+(0-5 millimeters)  2+(5-10 millimeters)  3+(10-15 millimeters)

**SECTION VIII - JOINT STABILITY/SUBLUXATION RESULTS**

8A. IS THERE EVIDENCE OR HISTORY OF RECURRENT PATELLAR SUBLUXATION/DISLOCATION?

YES  NO (*If "Yes," indicate severity and side affected*):

Right:  None  Slight  Moderate  Severe

Left:  None  Slight  Moderate  Severe

8B. IS THERE EVIDENCE OF INSTABILITY?

YES  NO (*If "Yes," indicate type of instability, severity and side affected*):

Right:  None  Slight  Moderate  Severe

Left:  None  Slight  Moderate  Severe

**SECTION IX - MENISCAL CONDITIONS, JOINT REPLACEMENT AND OTHER SURGICAL PROCEDURES**

9A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER HAD A MENISCUS (*semilunar cartilage*) CONDITION?

YES  NO

(*If "Yes," indicate severity and frequency of symptoms, and side affected*):

No symptoms  Right  Left  Both

Meniscal dislocation  Right  Left  Both

Meniscal tear  Right  Left  Both

Frequent episodes of joint "locking"  Right  Left  Both

Frequent episodes of joint pain  Right  Left  Both

Frequent episodes of joint effusion  Right  Left  Both

9B. HAS THE VETERAN HAD A MENISCECTOMY?

YES  NO (*If "Yes," indicate side affected*):  Right  Left  Both

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

Does the veteran have residual symptoms/signs?

YES  NO (*If "Yes," indicate side affected*):  Right  Left  Both

(*If "Yes," describe symptoms*):

**SECTION IX - MENISCAL CONDITIONS, JOINT REPLACEMENT AND OTHER SURGICAL PROCEDURES (Continued)**

9C. HAS THE VETERAN HAD A TOTAL KNEE JOINT REPLACEMENT?

- YES  NO (If "Yes," indicate side and severity of residuals)
- Right knee  
Date of surgery: \_\_\_\_\_  
Residuals:  
 None  
 Intermediate degrees of residual weakness, pain and/or limitation of motion  
 Chronic residuals consisting of severe painful motion and/or weakness  
 Other, describe: \_\_\_\_\_
- Left knee  
Date of surgery: \_\_\_\_\_  
Residuals:  
 None  
 Intermediate degrees of residual weakness, pain and/or limitation of motion  
 Chronic residuals consisting of severe painful motion and/or weakness  
 Other, describe: \_\_\_\_\_

9D. HAS THE VETERAN HAD ARTHROSCOPIC OR OTHER KNEE SURGERY?

- YES  NO (If "Yes," indicate side affected)  Right  Left  Both
- Date and type of surgery: \_\_\_\_\_

9E. DOES THE VETERAN HAVE ANY RESIDUAL SIGNS AND/OR SYMPTOMS DUE TO ARTHROSCOPIC OR OTHER KNEE SURGERY?

- YES  NO (If "Yes," indicate side affected):  Right  Left  Both
- (If "Yes," describe symptoms):

**SECTION X - ADDITIONAL CONDITIONS**

10. DOES THE VETERAN HAVE "SHIN SPLINTS" (medial tibial stress syndrome), CHRONIC EXERTIONAL COMPARTMENT SYNDROME, STRESS FRACTURE OR ANY OTHER TIBIAL AND/OR FIBULAR IMPAIRMENT?

- YES  NO
- (If "Yes," complete the following questions):
- A. Does the veteran have "shin splints" (medial tibial stress syndrome)?  
 YES  NO (If "Yes," indicate side affected):  Right  Left  Both  
Describe current symptoms: \_\_\_\_\_
- B. Does the veteran have chronic exertional compartment syndrome?  
 YES  NO (If "Yes," indicate side affected):  Right  Left  Both  
Describe current symptoms: \_\_\_\_\_
- C. Does the veteran have a stress fracture(s)?  
 YES  NO (If "Yes," indicate side affected):  Right  Left  Both  
Describe location and current symptoms: \_\_\_\_\_
- D. Does the veteran have evidence of acquired or traumatic genu recurvatum with weakness and insecurity in weight-bearing?  
 YES  NO (If "Yes," indicate side affected):  Right  Left  Both
- E. Does the veteran have leg length discrepancy or shortening of any bones in the lower extremity (leg length discrepancy)?  
 YES  NO  Right  Left  Both
- (If "Yes," provide leg length in inches (to the nearest 1/4 inch) or centimeters, measuring each lower extremity from anterior superior iliac spine to the internal malleolus of the tibia.)
- Measurements: Right leg: \_\_\_\_\_  cm  inches Left leg: \_\_\_\_\_  cm  inches

**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 DEVICES 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):*

<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: _____	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> 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 fro 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 KNEE(S) BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

YES  NO

*(If "Yes," is arthritis documented?)*

YES  NO

*(If "Yes," indicate knee)*  Right  Left  Both

13B. DOES THE VETERAN HAVE X-RAY EVIDENCE OF PATELLAR SUBLUXATION?

YES  NO

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

13C. 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 KNEE AND/OR LOWER LEG CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

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

13. 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](http://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 30 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](http://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.