



EYE 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.

NOTE - This examination must be conducted by a licensed optometrist or by a licensed ophthalmologist. The examiner must identify the disease, injury or other pathologic process responsible for any decrease in visual acuity or other visual impairment found. For VA purposes, examinations of visual fields and/or muscle function will be conducted ONLY when there is a medical indication of disease or injury that may be associated with visual field defect and/or impaired muscle [LA1] function. Unless medically contraindicated, the fundus must be examined with the claimant's pupils dilated.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN EYE CONDITION?

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

1B. PROVIDE RATIONALE (veteran does not currently have any known eye conditions)

1C. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO EYE CONDITION(S)

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1D. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO EYE CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

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

SECTION III - ANATOMICAL LOSS AND/OR LIGHT PERCEPTION ONLY

3A. DOES THE VETERAN HAVE ANATOMICAL LOSS OF EITHER EYE?

YES NO (If "Yes," indicate eye(s))
 RIGHT LEFT BOTH

3B. IS THE VETERAN'S VISION LIMITED TO NO MORE THAN LIGHT PERCEPTION ONLY IN EITHER EYE?

YES NO (If "Yes," indicate for which eye(s) the veteran's vision is limited to no more than light perception)
 RIGHT LEFT BOTH

3C. IS THE VETERAN ABLE TO RECOGNIZE TEST LETTERS AT 1 FOOT OR CLOSER?

YES NO (If "No," indicate with which eye(s) the veteran is unable to recognize test letters at 1 foot or closer)
 RIGHT LEFT BOTH

3D. IS THE VETERAN ABLE TO PERCEIVE OBJECTS, HAND MOVEMENTS, OR COUNT FINGERS AT 3 FEET?

YES NO (If "No," indicate with which eye(s) the veteran is unable to perceive objects, hand movements, or count fingers at 3 feet)
 RIGHT LEFT BOTH

SECTION IV - EXAMINATION

4-1 VISUAL ACUITY

NOTE - Examination of visual acuity must include the central uncorrected and its equivalent corrected visual acuity for distance and near vision using Snellen's test type or its equivalent. Visual acuity should not be determined with eccentric fixation or viewing. For VA purposes, visual acuity is evaluated according to the lines on the Snellen chart or its equivalent.

NOTE - If assessment of the veteran's visual acuity falls between two lines on the Snellen chart, round up to the higher (worse) level (poorer vision) for answers 4-1(A) through 4-1(D) below. (For example, 20/60 would be reported as 20/70; 20/80 would be reported as 20/100, etc.)

A. Uncorrected near:

RIGHT: 5/200* 20/400 15/200* 20/200 20/100 20/70 20/50 20/40 or better

LEFT: 5/200* 20/400 15/200* 20/200 20/100 20/70 20/50 20/40 or better

B. Uncorrected distance:

RIGHT: 5/200* 20/400 15/200* 20/200 20/100 20/70 20/50 20/40 or better

LEFT: 5/200* 20/400 15/200* 20/200 20/100 20/70 20/50 20/40 or better

C. Corrected near:

RIGHT: 5/200* 20/400 15/200* 20/200 20/100 20/70 20/50 20/40 or better

LEFT: 5/200* 20/400 15/200* 20/200 20/100 20/70 20/50 20/40 or better

D. Corrected distance:

RIGHT: 5/200* 20/400 15/200* 20/200 20/100 20/70 20/50 20/40 or better

LEFT: 5/200* 20/400 15/200* 20/200 20/100 20/70 20/50 20/40 or better

* The measurement of 5/200 and 15/200 visual acuity may be accomplished through several methods, such as by having the patient/veteran walk up to the 20/200 Snellen test type chart at 5 feet and 15 feet respectively or by using another Snellen test type or its equivalent chart to measure visual acuity at comparable distances.

E. Was the corrected visual acuity determined with standard spectacle correction (e.g., phoropter or trial frame exam)?

Yes No

F. Does the veteran customarily wear contact lenses to correct for a corneal irregularity?

Yes No

(If "Yes," was the corrected visual acuity determined with habitual contact lens correction in place and standard spectacle correction over refraction?)

Yes No

(If "No," explain):

G. Does the veteran have legal (statutory) blindness (visual acuity of 20/200 or less in the better eye with use of a correcting lens) based upon visual acuity loss?

Yes No

4-2 VISUAL ACUITY DIFFERENCES

NOTE - For VA purposes, in any case where the examiner reports that there is a difference equal of two or more lines on the Snellen test type chart or its equivalent between near and distance corrected vision, with the near vision being worse, the examiner must provide at least 2 recordings of corrected near and distance vision and explain the reason for the difference.

A. Is there a difference equal of two or more lines on the Snellen test type chart or its equivalent between near and distance corrected vision, with the near vision being worse?

Yes No

(If "Yes," explain reason for the difference):

B. Does the lens required to correct distance vision in the poorer eye differ by more than 3 diopters from the lens required to correct distance vision in the better eye?

Yes No

(If "Yes," explain reason for the difference):

C. If the answer to 4-2(A) or 4-2(B) is yes, provide a second recording of corrected near and distance vision

Second recording of corrected near vision:

RIGHT: 5/200* 20/400 15/200* 20/200 20/100 20/70 20/50 20/40 or better

LEFT: 5/200* 20/400 15/200* 20/200 20/100 20/70 20/50 20/40 or better

Second recording of corrected distance vision:

RIGHT: 5/200* 20/400 15/200* 20/200 20/100 20/70 20/50 20/40 or better

LEFT: 5/200* 20/400 15/200* 20/200 20/100 20/70 20/50 20/40 or better

SECTION IV - EXAMINATION (Continued)

4-3 PUPILS

Pupils:

- Pupils are round and reactive to light
- Afferent papillary defect, describe [LA2]: _____
- Other, describe: _____

Pupil diameter: Right: _____ mm Left: _____ mm

4-4 DIPLOPIA

A. Does the veteran have diplopia?

- Yes No

(If "Yes," provide etiology (such as traumatic injury, thyroid eye disease, myasthenia gravis, etc.)

(If "Yes," chart the areas of diplopia on a Goldman perimeter chart that identifies the four major quadrants (upward, downward, left lateral and right lateral) and the central field (20 degrees or less) and include the chart with this questionnaire)

Include the results from the Goldman perimeter chart below:

Right eye:

- Up: _____ degrees
- Down: _____ degrees
- Right lateral: _____ degrees
- Left lateral: _____ degrees

Left eye:

- Up: _____ degrees
- Down: _____ degrees
- Right lateral: _____ degrees
- Left lateral: _____ degrees

B. Is the diplopia occasional?

- Yes No

(If "Yes," indicate frequency of diplopia and most recent occurrence [LA3]): _____

C. Is the diplopia correctable with standard spectacle correction?

- Yes No

(If "No," is the diplopia correctable with standard spectacle correction that includes a special prismatic correction [LA4][LA5]?)

- Yes No

D. Is the veteran's diplopia secondary to a cranial nerve or extraocular muscle weakness [LA6]/paralysis?

- Yes No

(If "Yes," indicate cranial nerve(s), extraocular muscle(s) and side affected: (check all that apply))

- | | | | |
|---|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> 3rd cranial nerve (oculomotor) paresis/paralysis | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> 4th cranial nerve (trochlear) paresis/paralysis | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> 6th cranial nerve (abducens) paresis/paralysis | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Superior rectus | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Medial rectus | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Inferior rectus | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Lateral rectus | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Superior oblique | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Inferior oblique | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |

SECTION IV - EXAMINATION (Continued)

4-5 VISUAL FIELDS

A. Are visual fields intact to confrontation [LA7]?

Yes No

B. Does the veteran have a visual field defect?

Yes No

(If "Yes," complete 4-5(C) through 4-5(G) below):

NOTE - If the veteran has a visual field defect, examiners must perform visual field testing using either Goldmann kinetic perimetry or automated perimetry using Humphrey Model 750, Octopus Model 101, or later versions of these perimetric devices with simulated kinetic Goldmann testing capability. Report the findings on a standard Goldmann chart and include the chart with this questionnaire [LA8].

C. Was visual fields testing performed?

Yes No

Results: Using Goldmann's equivalent III/4e isopter Using Goldmann's equivalent IV/4e isopter [LA9]

Date of exam:

<input type="checkbox"/> Superior:	(normal 45)	Right: _____ degrees	Left: _____ degrees
<input type="checkbox"/> Superior-temporal:	(normal 55)	Right: _____ degrees	Left: _____ degrees
<input type="checkbox"/> Superior-nasal:	(normal 55)	Right: _____ degrees	Left: _____ degrees
<input type="checkbox"/> Inferior:	(normal 65)	Right: _____ degrees	Left: _____ degrees
<input type="checkbox"/> Inferior-temporal:	(normal 85)	Right: _____ degrees	Left: _____ degrees
<input type="checkbox"/> Inferior-nasal:	(normal 50)	Right: _____ degrees	Left: _____ degrees
<input type="checkbox"/> Nasal:	(normal 60)	Right: _____ degrees	Left: _____ degrees
<input type="checkbox"/> Temporal:	(normal 85)	Right: _____ degrees	Left: _____ degrees

Single:

Right 0 degrees: _____ degrees	Left 0 degrees: _____ degrees
Right 90 degrees: _____ degrees	Left 90 degrees: _____ degrees
Right 180 degrees: _____ degrees	Left 180 degrees: _____ degrees
Right 270 degrees: _____ degrees	Left 270 degrees: _____ degrees

Double:

Right 0 degrees: _____ degrees	Left 0 degrees: _____ degrees
Right 90 degrees: _____ degrees	Left 90 degrees: _____ degrees
Right 180 degrees: _____ degrees	Left 180 degrees: _____ degrees
Right 270 degrees: _____ degrees	Left 270 degrees: _____ degrees

D. Does the veteran have contraction of a visual field?

Yes No

(If "Yes," for VA purposes, calculate average concentric contraction of the visual field of each eye by measuring the remaining visual field in degrees at each of the 8 principal meridians, adding them, and dividing the sum by 8)

Right average concentric contraction: _____

Left average concentric contraction: _____

E. Does the veteran have loss of a visual field?

Yes No

(If "Yes," check all that apply and indicate side):

Homonymous hemianopsia	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
Loss of temporal half of visual field	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
Loss of nasal half of visual field	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
Loss of inferior half of visual field	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
Loss of superior half of visual field	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
Other (specify) _____	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH

F. Does the veteran have a scotoma?

Yes No

(If "Yes," check all that apply and indicate side):

<input type="checkbox"/> Scotoma affecting at least 1/4 of the visual field	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
<input type="checkbox"/> Centrally located scotoma	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH

G. Does the veteran have legal (statutory) blindness (visual field diameter of 20 degrees or less in the better eye, even if the corrected visual acuity is 20/20) based upon visual field loss?

Yes No

SECTION IV - EXAMINATION (Continued)

4-6 TONOMETRY

Tonometry:

Applanation

Other, describe [LA11]: _____

Dilatation: RIGHT LEFT BOTH Time: _____ Tropicamide: _____ %

4-7 SLIT LAMP EXAM

All normal (check this box only if all physical exam findings, a-k, below are normal [LA12])

A. External exam/lids/lashes

Right: Normal Other, describe: _____
 Left: Normal Other, describe: _____

B. Conjunctiva

Right: Normal Other, describe: _____
 Left: Normal Other, describe: _____

C. Cornea

Right: Normal Other, describe: _____
 Left: Normal Other, describe: _____

D. Anterior chamber

Right: Normal Other, describe: _____
 Left: Normal Other, describe: _____

E. Iris

Right: Normal Other, describe: _____
 Left: Normal Other, describe: _____

F. Lens

Right: Normal Other, describe: _____
 Left: Normal Other, describe: _____

G. Fundus

Right: Normal Other, describe: _____
 Left: Normal Other, describe: _____

H. Macula

Right: Normal Other, describe: _____
 Left: Normal Other, describe: _____

I. Vessels

Right: Normal Other, describe: _____
 Left: Normal Other, describe: _____

J. Vitreous

Right: Normal Other, describe: _____
 Left: Normal Other, describe: _____

K. Periphery

Right: Normal Other, describe: _____
 Left: Normal Other, describe: _____

SECTION V - EYE CONDITIONS

A. Does the veteran have any of the following eye conditions?

Yes No (If "No," proceed to Section VI)

(If "Yes," indicate the eye condition(s), checking all that apply)

- Anatomical loss of eyelids and/or brows (If checked complete 5-1(B))
- Lacrimal gland and lid (If checked complete 5-2(C))
- Ptosis, in either or both eyes (If checked complete 5-3(D))
- Conjunctivitis and other conjunctival conditions (If checked complete 5-4(E))
- Corneal conditions (If checked complete 5-5(F))
- Inflammatory eye conditions/injuries (If checked complete 5-6(G))
- Glaucoma (If checked complete 5-7(H))
- Cataracts and lens conditions (If checked complete 5-8(I))
- Retinal eye conditions (If checked complete 5-9(J))
- Neurologic eye conditions (If checked complete 5-10(K))
- Neoplasms (If checked complete 5-11(L))
- Other eye condition(s) (specify) _____ (If checked complete 5-12(M))

SECTION V - EYE CONDITIONS (Continued)

5-1 ANATOMICAL LOSS OF EYELIDS AND/OR BROWS

B. Indicate the veteran's condition(s) and side affected

- Partial or complete loss of eyelid(s) RIGHT LEFT BOTH
 Complete loss of eyebrows RIGHT LEFT BOTH
 Complete loss of eyelashes RIGHT LEFT BOTH

Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to eyelid loss condition?

- Yes No There is no decrease in visual acuity or other visual impairment

(If "No," explain): _____

If present, does eyelid loss cause scarring or disfigurement?

- Yes No

(If "Yes," complete scarring and disfigurement in Section VI)

5-2 LACRIMAL GLAND AND LID CONDITIONS

C. Indicate the veteran's condition(s) and side affected (check all that apply)

- Ectropion RIGHT LEFT BOTH
 Entropion RIGHT LEFT BOTH
 Lagophthalmos RIGHT LEFT BOTH
 Disorders of the lacrimal apparatus
(epiphora, dacryocystitis, etc.) RIGHT LEFT BOTH

5-3 PTOSIS

D. If ptosis is present, indicate side affected: RIGHT LEFT BOTH

Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to ptosis?

- Yes No There is no decrease in visual acuity or other visual impairment

(If "No," explain): _____

Does the Ptosis loss cause disfigurement?

- Yes No

(If "Yes," complete scarring and disfigurement in Section VI)

5-4 CONJUNCTIVITIS AND OTHER CONJUNCTIVAL CONDITIONS

E. Indicate type of conjunctivitis, activity, and side affected (check all that apply):

- Trachomatous
 Active
 Inactive
If present, indicate side affected RIGHT LEFT BOTH
 Nontrachomatous
 Active
 Inactive
If present, indicate side affected RIGHT LEFT BOTH

Indicate the veteran's other conjunctival conditions, if any (check all that apply)

- Pinguecula: if present, indicate side affected RIGHT LEFT BOTH
 Symblepharon: if present, indicate side affected RIGHT LEFT BOTH
 Other, describe: _____ RIGHT LEFT BOTH

Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the eye conditions checked above in this section?

- Yes No There is no decrease in visual acuity or other visual impairment

(If "No," explain): _____

Does this eye condition cause scarring or disfigurement?

- Yes No

(If "Yes," complete scarring and disfigurement in Section VI)

5-5 CORNEAL CONDITIONS

F. Has the veteran had a corneal transplant?

- Yes No

(If "Yes," indicate residuals and side affected (check all that apply))

- Pain RIGHT LEFT BOTH
Photophobia RIGHT LEFT BOTH
Glare sensitivity RIGHT LEFT BOTH
Other, describe: _____ RIGHT LEFT BOTH

SECTION V - EYE CONDITIONS (Continued)

5-5 CORNEAL CONDITIONS (Continued)

Does the veteran have keratoconus?

Yes No (If "Yes," indicate side affected) RIGHT LEFT BOTH

Does the veteran have pterygium?

Yes No (If "Yes," indicate side affected) RIGHT LEFT BOTH

Does the veteran have another corneal condition that may result in an irregular cornea? (For example, pellucid marginal degeneration, irregular astigmatism from corneal scar, post-laser refractive surgery, acne rosacea keratopathy, etc.)

Yes No

(If "Yes," specify corneal condition and indicate side affected)

RIGHT LEFT BOTH

Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to keratoconus or another corneal condition, if present?

Yes No There is no decrease in visual acuity or other visual impairment

(If "No," explain): _____

5-6 INFLAMMATORY EYE CONDITIONS AND/OR INJURIES

G. Indicate the veteran's condition and side affected:

<input type="checkbox"/> Choroidopathy (including uveitis, iritis, cyclitis, and choroiditis)	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
<input type="checkbox"/> Keratopathy	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
<input type="checkbox"/> Scleritis	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
<input type="checkbox"/> Intraocular hemorrhage	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
<input type="checkbox"/> Unhealed eye injury	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
<input type="checkbox"/> Other, describe: _____	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH

Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any eye condition and/or injury checked above?

Yes No There is no decrease in visual acuity or other visual impairment

(If "No," explain): _____

During the past 12 months, has the veteran had any incapacitating episodes attributable to any eye condition and/or injury checked [LA13] above?

Yes No

(If "Yes," complete Section VII)

5-7 GLAUCOMA

H. Specify the type of glaucoma:

<input type="checkbox"/> Angle-closure	Eye affected:	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
<input type="checkbox"/> Open-angle	Eye affected:	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
<input type="checkbox"/> Other, specify type (For example, neovascular, phakolytic, etc.)	Eye affected:	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH

Does the glaucoma require continuous medication for treatment?

Yes No (If "Yes," indicate side affected) RIGHT LEFT BOTH

List medication(s) used for treatment of glaucoma: _____

Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to the type of glaucoma eye condition checked above?

Yes No There is no decrease in visual acuity or other visual impairment

(If "No," explain): _____

During the past 12 months, has the veteran had any incapacitating episodes attributable to the type of glaucoma eye condition checked above?

Yes No

(If "Yes," complete Section VII)

5-8 CATARACT AND LENS CONDITIONS

I. Indicate cataract condition [LA14]

<input type="checkbox"/> Non-operative (If a cataract is present, check "non-operative" if surgery is not indicated at the present time)	If present, indicate eye affected:	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
<input type="checkbox"/> Preoperative (If a cataract is present, check "preoperative" if surgery is not indicated at the present time)	If present, indicate eye affected:	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH
<input type="checkbox"/> Postoperative (If "postoperative," is there a replacement intraocular lens?)	If present, indicate eye affected:	<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BOTH

Is there aphakia or dislocation of the crystalline lens?

Yes No (If "Yes," indicate side affected) RIGHT LEFT BOTH

Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to the cataract or lens eye condition checked above?

Yes No There is no decrease in visual acuity or other visual impairment

(If "No," explain): _____

SECTION V - EYE CONDITIONS (Continued)

5-9 RETINOL CONDITIONS

J. Indicate cataract condition [LA14]:

- | | | | | |
|---|------------------------|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Retinopathy | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Maculopathy | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Detached retina | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Retinal hemorrhage | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Unhealed eye injury | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Centrally located retinal scars, atrophy or irregularities in either eye that result in an irregular, duplicated, enlarged or diminished image in either eye | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |

Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to the cataract eye condition checked above?

- Yes No There is no decrease in visual acuity or other visual impairment

During the past 12 months, has the veteran had any incapacitating episodes attributable to the cataract eye condition checked above?

- Yes No (If "Yes," complete Section VII)

5-10 NEUROLOGIC EYE CONDITIONS

K. Indicate the veteran's neurologic eye condition/disorder:

- | | | | | |
|--|------------------------|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Nystagmus (If checked, specify type (For example central, endpoint, pendular, etc.): _____) | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Paresis/paralysis of 3rd cranial nerve (oculomotor) | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Paresis/paralysis of 4th cranial nerve (trochlear) | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Paresis/paralysis of 6th cranial nerve (abducens) | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Paresis/paralysis of 7th cranial nerve (facial, Bell's palsy) | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Cerebrovascular accident (CVA) (If checked, specify location): _____ | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |

(For example: optic nerve, pre-chiasmal, post-chiasmal, optic tract, lateral geniculate body, temporal lobe, parietal lobe, occipital lobe)

- | | | | | |
|--|------------------------|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Optic neuritis | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
| <input type="checkbox"/> Intracranial mass/tumor (If checked, specify location): _____ | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |

(For example: optic nerve, pre-chiasmal, post-chiasmal, optic tract, lateral geniculate body, temporal lobe, parietal lobe, occipital lobe)

- Traumatic brain injury (TBI) (If checked, describe effect of TBI on eye conditions): _____

- | | | | | |
|---|------------------------|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Other, specify condition/disorder (For example, Alzheimer's disease, Jakob-Creutzfeldt disease, etc.): _____ | Specify side affected: | <input type="checkbox"/> RIGHT | <input type="checkbox"/> LEFT | <input type="checkbox"/> BOTH |
|---|------------------------|--------------------------------|-------------------------------|-------------------------------|

(If checked, specify location): _____

(For example: optic nerve, pre-chiasmal, chiasmal, post-chiasmal, optic tract, lateral geniculate body, temporal lobe, parietal lobe, occipital lobe)

Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to the neurologic condition/disorder checked above?

- Yes No There is no decrease in visual acuity or other visual impairment

(If "No," explain): _____

During the past 12 months, has the veteran had any incapacitating episodes attributable to the neurologic eye condition checked above?

- Yes No (If "Yes," complete Section VII)

5-11 NEOPLASMS

L. Does the veteran have an ophthalmic neoplasm?

- Yes No (If "Yes," also complete VA Form 21-09600-1, Tumors and Neoplasms Disability Benefits Questionnaire)

5-12 OTHER EYE CONDITIONS, PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

M. Does the veteran have any other eye conditions, pertinent physical findings, complications, conditions, signs and/or symptoms?

- Yes No (If "Yes," describe): _____

SECTION VI - SCARRING AND DISFIGUREMENT FOR EYE CONDITIONS

NOTE: Include color photographs with any report of scarring or disfigurement.

6. DOES THE VETERAN HAVE SCARRING ATTRIBUTABLE TO ANY EYE CONDITION?

 YES NO*(If "Yes," indicate scar attributes (check all that apply))*

- Scar at least one-quarter inch (0.6cm) wide at widest part
- Surface contour of scar elevated or depressed on palpation *(or inspection in the case of sclera)*
- Scar adherent to underlying tissue *(including eyelids adherent to scleral tissue)*
- Visible or palpable tissue loss
- Gross distortion or asymmetry of one feature or paired set of features *(eyes)*

SECTION VII - INCAPACITATING EPISODES

NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician or other healthcare provider (For example, temporary bed rest required for a retinal condition).

7A. DURING THE PAST 12 MONTHS, HAS THE VETERAN HAD ANY INCAPACITATING EPISODES ATTRIBUTABLE TO ANY EYE CONDITIONS?

 YES NO*(If "Yes," specify the eye condition(s) causing incapacitating episodes [LA15]):**(If "Yes," describe how the eye condition(s) caused incapacitating episodes):*

7B. PROVIDE THE TOTAL DURATION FOR THE INCAPACITATING EPISODES FOR ALL INCAPACITATING CONDITIONS OVER THE PAST 12 MONTHS

- LESS THAN 1 WEEK
- AT LEAST 1 WEEK BUT LESS THAN 2 WEEKS
- AT LEAST 2 WEEKS BUT LESS THAN 4 WEEKS
- AT LEAST 4 WEEKS BUT LESS THAN 6 WEEKS
- AT LEAST 6 WEEKS

SECTION VIII - FUNCTIONAL IMPACT AND REMARKS

8. DOES THE VETERAN'S EYE CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

 YES NO *(If "Yes," describe the impact of each of the veteran's eye condition(s), providing one or more examples)*9. REMARKS *(If any)***SECTION X - OPTOMETRIST/PHYSICIAN'S CERTIFICATION AND SIGNATURE****CERTIFICATION** - To the best of my knowledge, the information contained herein is accurate, complete and current.

10A. OPTOMETRIST/PHYSICIAN'S SIGNATURE

10B. OPTOMETRIST/PHYSICIAN'S PRINTED NAME

10C. DATE SIGNED

10D. OPTOMETRIST/PHYSICIAN'S PHONE NUMBER

10E. OPTOMETRIST/PHYSICIAN'S MEDICAL LICENSE NUMBER

10F. OPTOMETRIST/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 45 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.