OMB Approved No. 2900-XXXX
Respondent Burden: 30 minutes

Department of Veterans Affairs

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 FLATFOOT (PES PLANUS)?

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

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

1C. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO FLATFOOT

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED ☐ RIGHT ☐ LEFT ☐ BOTH
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED ☐ RIGHT ☐ LEFT ☐ BOTH
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED ☐ RIGHT ☐ LEFT ☐ BOTH

1D. IF ADDITIONAL DIAGNOSES PERTAINING TO FLATFOOT, LIST USING ABOVE FORMAT

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S CURRENT FLATFOOT CONDITION *(i.e., when did flatfoot first become symptomatic?) (brief summary)*

SECTION III - SIGNS AND SYMPTOMS

3. INDICATE ALL SIGNS AND SYMPTOMS THAT APPLY TO THE VETERAN'S FLATFOOT CONDITION, REGARDLESS OF WHETHER SIMILAR SIGNS AND SYMPTOMS APPEAR MORE THAN ONCE IN DIFFERENT SECTIONS

A. DOES THE VETERAN HAVE DECREASED LONGITUDINAL ARCH HEIGHT ON WEIGHT-BEARING?

☐ YES ☐ NO

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

B. ARE THE VETERAN'S SYMPTOMS RELIEVED BY ARCH SUPPORTS (OR BUILT UP SHOES OR ORTHOTICS)?

☐ YES ☐ NO

If "No," indicate side that remains symptomatic ☐ Right ☐ Left ☐ Both

C. DOES THE VETERAN HAVE PAIN ON MANIPULATION OF THE FEET?

☐ YES ☐ NO

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

If "Yes," is the pain on manipulation accentuated?

☐ YES ☐ NO

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

SECTION III - SIGNS AND SYMPTOMS *(Continued)*

D. DOES THE VETERAN HAVE PAIN ON USE OF THE FEET?

☐ YES ☐ NO

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

If "Yes," is the pain on use accentuated?

☐ YES ☐ NO

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

E. IS THERE INDICATION OF SWELLING ON USE?

☐ YES ☐ NO

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

F. DOES THE VETERAN HAVE CHARACTERISTIC CALLUSES (OR ANY CALLUSES CAUSED BY THE FLATFOOT CONDITION)?

☐ YES ☐ NO

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

G. DOES THE VETERAN HAVE EXTREME TENDERNESS OF PLANTAR SURFACES OF THE FEET?

☐ YES ☐ NO

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

Is it improved by orthopedic shoes or appliances?

☐ YES ☐ NO

NOTE - If the veteran has extreme tenderness on the plantar surfaces of the feet indicating plantar fascitis, also complete VA Form 21-0960M-6, Foot Miscellaneous (other than Flatfoot/Pes Planus) Disability Benefits Questionnaire.

SECTION IV - ALIGNMENT AND DEFORMITY

4. ALIGNMENT AND DEFORMITY OF THE FOOT

A. IS THERE OBJECTIVE EVIDENCE OF MARKED DEFORMITY OF THE FOOT *(PRONATION, ABDUCTION ETC.)*?

☐ YES ☐ NO

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

B. IS THERE MARKED PRONATION OF THE FOOT?

☐ YES ☐ NO

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

if "Yes," is the condition improved by orthopedic shoes or appliances?

☐ YES ☐ NO

C. DOES THE WEIGHT-BEARING LINE FALL OVER OR MEDIAL TO THE GREAT TOE?

☐ YES ☐ NO

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

D. IS THERE A LOWER EXTREMITY DEFORMITY OTHER THAN PES PLANUS, CAUSING ALTERATION OF THE WEIGHT-BEARING LINE?

☐ YES ☐ NO

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

Describe lower extremity deformity causing alteration of the weight bearing line: _____

E. DOES THE VETERAN HAVE "INWARD" BOWING OF THE ACHILLES' TENDON *(i.e., hind foot valgus, with lateral deviation of the heel)*?

☐ YES ☐ NO

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

F. DOES THE VETERAN HAVE MARKED INWARD DISPLACEMENT AND SEVERE SPASM OF THE ACHILLES' TENDON *(rigid hindfoot)* ON MANIPULATION?

☐ YES ☐ NO

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

if "Yes," is the condition improved by orthopedic shoes or appliances?

☐ YES ☐ NO

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

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

☐ YES ☐ NO

(If "Yes," describe): _____

SECTION VI - DIAGNOSTIC TESTING

NOTE - Plain or weight-bearing foot x-rays are not required to make the diagnosis of flatfoot. 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.

6A. HAVE IMAGING STUDIES OF THE FOOT BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

(If "Yes," is arthritis documented?)

☐ YES ☐ NO

(If "Yes," indicate foot)

☐ Right ☐ Left ☐ Both

6B. 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 VII - FUNCTIONAL IMPACT AND REMARKS

7. DOES THE VETERAN'S FLATFOOT CONDITION IMPACT HIS OR HER ABILITY TO WORK?

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

8. REMARKS *(If any)*

SECTION VIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9A. PHYSICIAN'S SIGNATURE	9B. PHYSICIAN'S PRINTED NAME	9C. DATE SIGNED

9D. PHYSICIAN'S PHONE NUMBER	9E. PHYSICIAN'S MEDICAL LICENSE NUMBER	9F. 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.