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

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

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 ☐ 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 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):

☐ 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 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 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. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.