OMB Approved No. 2900-0052
Respondent Burden: 15 minutes

REPORT OF MEDICAL EXAMINATION FOR DISABILITY EVALUATION

1A. FILE NO. C/CSS-	1B. VETERAN'S SOCIAL SECURITY NO.
2. INSURANCE FILE NO. *(V,H,K, etc., if pertinent)*	

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, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, and 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 this 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.

INSTRUCTIONS TO THE VETERAN: Please complete all unshaded items on Page 1 of this form. Bring this form with you when reporting for the examination.

3. FIRST, MIDDLE, LAST NAME OF VETERAN *(Type or print)*	4. PURPOSE OF EXAMINATION	5. DATE OF EXAMINATION
6. HOME ADDRESS *(Street or RFD Number, City, State and ZIP Code)*	7. PLACE OF EXAMINATION	8. AGE OF VETERAN

SECTION A - OCCUPATIONAL HISTORY SINCE LATEST DISCHARGE FROM MILITARY SERVICE OR LATEST VA EXAMINATION

9. NAME AND ADDRESS OF EMPLOYER *(If unemployed enter "None")*	10. TYPE OF WORK	11. MONTHLY WAGES	12. DATES OF EMPLOYMENT		13. TIME LOST IN PAST 12 MONTHS
			FROM	TO	

14. REASON FOR TIME LOST *(If any)*

SECTION B - MEDICAL HISTORY SINCE LATEST VA EXAMINATION AS RELATED BY PERSON EXAMINED

15. NARRATIVE HISTORY *(Include manner and date of origin)*

NAME AND ADDRESS OF DOCTOR OR HOSPITAL	CONDITION TREATED	FROM	TO
16A.			
16B.			
16C.			

17. PRESENT COMPLAINT *(Symptoms only, not diagnosis)*

I HEREBY CERTIFY that the entries under Occupational and Medical History are complete and correct to the best of my knowledge.

18. DATE SIGNED	19. SIGNATURE OF PERSON EXAMINED *(Do Not Print)*

PENALTY - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

SECTION C - EXAMINATION *(Examinee must be stripped)*

INSTRUCTIONS TO THE EXAMINING PHYSICIAN: This report must be completely executed. Describe the results of a general examination of every system and body parts including but not restricted to the systems and body parts involved in the history and present complaints. Wherever indicated specialists' examinations. X-rays, laboratory examinations, etc., should be recommended. If additional space is needed, comments may be continued in Item 44, "Remarks" or on separate sheets attached to this form.

20. HEIGHT	21. WEIGHT	22. MAX. WT. PAST YEAR	23. BUILD AND STATE OF NUTRITION	24. TEMPERATURE
		lbs.		DEGREES
25. CARRIAGE	26. POSTURE	27. GAIT	28. RIGHT-OR-LEFT-HANDED HOW DETERMINED	AT AM PM

29. SKIN-INCLUDING APPENDAGES *(Describe type, area, and extent of lesions. Report injuries, including burns, under Item 4)*

30. LYMPHATIC AND HEMIC SYSTEMS *(Describe local or generalized adenopathy, enlargement, tenderness, suppuration, blocking of lymphatic circulation, etc.)*

31. HEAD, FACE AND NECK

32. NOSE, SINUSES, MOUTH, AND THROAT *(Include gross denial findings)*

33A. EARS *(Describe canals, drums, perforations, discharge)*

33B. HEARING LOSS NOTED

☐ YES

☐ NO

34A. EYES *(Describe external eye, pupil reaction, movements and field of vision)*

34B. DISTANT VISION	
R20/	CORRECTED TO 20/
L20/	CORRECTED TO 20/

35A. CARDIOVASCULAR SYSTEM *(Describe thrust, size, rhythm, sounds, and condition of peripheral vessels)*

	35B. PULSE	35C. BLOOD PRESSURE	35D. RESPIRATION	35E. IF NOT EXERCISED, GIVE REASON
SITTING		S D		
RECUMBENT		S D		
STANDING		S D		
SITTING AFTER EXERCISE		S D		
2 MIN. AFTER EXERCISE		S D		

36A. VARICOSE VEINS *(Describe location, size, extent, ulcers, scars, and competency of deep circulation)*

36B. ARE ELASTIC STOCKINGS NECESSARY?

☐ YES ☐ NO

36C. IS OPERATION RECOMMENDED?

☐ YES ☐ NO

Attach Continuation Sheets, Specialists' Reports, Laboratory Reports, etc., in this space.

37A. RESPIRATORY SYSTEM *(Describe cough, expectoration, mobility, palpation, percussion, and auscultation and specify area)*	37B. SHAPE OF CHEST
	37C. EXPIRATION INCHES
	37D. INSPIRATION INCHES

38. DIGESTIVE SYSTEM *(Describe findings on inspection and palpation, enlargements, masses, tenderness, rigidity, hemorrhoids (internal or external)*

39. HERNIA *(Describe type, location, size, whether complete, reducible, recurrent, retained by truss, and whether operable)*

40. GENITO-URINARY SYSTEM *(Describe kidneys, bladder, prostate, seminal vesicles, testes, cord, penis, and appendages; evidence of past or present venereal disease; in females report pelvic exam, if indicated)*

41. MUSCULO-SKELETAL SYSTEM
(A-DISEASES and INJURIES, include effect of gunshot wounds and other injuries on skin and underlying structures.

B-SCARS, describe location, measurements, depression, type of tissue loss, adherence, disfigurement, and tenderness.

C-FUNCTIONAL EFFECTS, describe location, swelling, atrophy, tenderness, degree of limitation of flexion and extension, angle of fixation, fracture, disease, fibrous or bony residual, and specify mechanical aid used and benefit.

D-FEET, describe objective evidence of pain at rest and on manipulation, rigidity, spasm, circulatory disturbance, swelling, callus, strength, mobility of ankles, feet, toes, and limitation in degrees and indicate whether right or left, acquired or congenital.

E-BURNS, degree and area in square inches.)

42. ENDOCRINE SYSTEM *(Describe disease of thyroid, pituitary, adrenals, pancreas, gonads, etc.)*

43. NERVOUS SYSTEM (A-NEUROLOGICAL, describe motor status, coordination, reflexes, sensory status, equilibrium, and give exact location. B-PSYCHIATRIC and PERSONALITY, describe behavior, comprehension, coherence of response, emotional reaction, orientation, memory, signs of tension and status as to social and industrial capacity.)
44. REMARKS *(Cite the item number(s) continued in this space)*

45A. LABORATORY TESTS, X-RAYS, BMR, EKG, ETC.	45B. DATE MADE	45C. URINALYSIS		
		SPECIFIC GRAVITY	ALBUMIN	SUGAR
		MICROSCOPIC		

45D. OTHER TESTS RECOMMENDED, ETC.
46. DIAGNOSIS

47A. IS EXAMINEE BEDRIDDEN?	47B. IS HOSPITALIZATION NEEDED?	47C. WILL EXAMINEE ACCEPT HOSPITALIZATION?
48A. IS EXAMINEE ABLE TO TRAVEL?	48B. ALONE?	48C. WITH ATTENDANT?

49. SPECIALISTS EXAMINATIONS RECOMMENDED

50. SIGNATURE OF PHYSICIAN	NAME AND SPECIALTY *(Type or print)*	DATE SIGNED
51. SIGNATURE OF PHYSICIAN	NAME AND SPECIALTY *(Type or print)*	DATE SIGNED
52. SIGNATURE OF PHYSICIAN	NAME AND SPECIALTY *(Type or print)*	DATE SIGNED

53. ATTACHMENTS MADE A PART OF THIS EXAMINATION *(List by number or describe)*