OMB Approved No. 2900-0776
Respondent Burden: 30 minutes

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 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 NOW HAVE OR HAS HE/SHE EVER HAD A KNEE AND/OR LOWER LEG CONDITION?

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

1B. 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

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

SECTION II - MEDICAL HISTORY

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

SECTION III - FLARE-UPS

3. 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 IV - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS

MEASURE ROM WITH A GONIOMETER, ROUNDING EACH MEASUREMENT TO THE NEAREST 5 DEGREES. DURING THE MEASUREMENTS, DOCUMENT THE POINT AT WHICH PAINFUL MOTION BEGINS, EVIDENCED BY VISABLE BEHAVIOR SUCH AS FACIAL EXPRESSION, WINCING, ETC. REPORT POST-TEST MEASUREMENTS IN SECTION 5.

FOLLOWING THE INITIAL ASSESSMENT OF ROM, PERFORM REPETITIVE USE TESTING. FOR VA PURPOSES, REPETITIVE USE TESTING MUST BE INCLUDED IN ALL JOINT EXAMS. THE VA HAS DETERMINED THAT 3 REPETITIONS OF ROM (*at a minimum*) CAN SERVE AS A REPRESENTATIVE TEST OF THE EFFECT OF REPETITIVE USE. AFTER THE INITIAL MEASUREMENT, REASSESS ROM AFTER 3 REPETITIONS. REPORT POST-TEST MEASUREMENTS IN SECTION 5.

4A. RIGHT KNEE FLEXION

SELECT WHERE 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

SELECT WHERE OBJECTIVE EVIDENCE OF PAINFUL MOTION BEGINS:

☐ No objective evidence of painful motion
☐ 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

4B. RIGHT KNEE EXTENSION

Select where 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 IV - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS *(Continued)*

4B. RIGHT KNEE EXTENSION (Continued)

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion

☐ 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 FLEXION

SELECT WHERE 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

SELECT WHERE OBJECTIVE EVIDENCE OF PAINFUL MOTION BEGINS:

☐ No objective evidence of painful motion

☐ 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

4D. LEFT KNEE EXTENSION

Select where 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

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion

☐ 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

4E. 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 V - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING

5A. IS VETERAN ABLE TO PERFORM REPETITIVE-USE TESTING WITH 3 REPETITIONS?

☐ YES ☐ NO

(If unable, provide reason):

(If Veteran is unable to perform repetitive-use testing, skip to section 6)

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

5B. RIGHT KNEE POST-TEST ROM

Select where 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

Select where 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

5C. LEFT KNEE POST-TEST ROM

Select where 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

Select where 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 VI - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION IN ROM

The following section addresses reasons for functional loss, if present, and additional loss of ROM after repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance.

6A. DOES THE VETERAN HAVE ADDITIONAL LIMITATION IN ROM OF THE KNEE AND LOWER LEG FOLLOWING REPETITIVE-USE TESTING?

☐ YES ☐ NO

6B. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS AND/OR FUNCTIONAL IMPAIRMENT OF THE KNEE AND LOWER LEG?

☐ YES ☐ NO

6C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT OR ADDITIONAL LIMITATION OF ROM OF THE KNEE AND LOWER LEG AFTER REPETITIVE USE, INDICATE THE CONTRIBUTING FACTORS OF DISABILITYBELOW *(check all that apply and indicate side affected)*:

☐ NO FUNCTIONAL LOSS FOR RIGHT LOWER EXTREMITY

☐ NO FUNCTIONAL LOSS FOR LEFT LOWER EXTREMITY

Factor			
☐ 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

☐ OTHER, DESCRIBE:

SECTION VII - PAIN (PAIN ON PALPATION)

7. DOES THE VETERAN HAVE TENDERNESS OR PAIN TO PALPATION FOR JOINT LINE OR SOFT TISSUES OF EITHER KNEE?

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

SECTION VIII - PAINFUL MOTION, TENDERNESS AND STRENGTH TESTING

8. 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 flexion:	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
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 IX - JOINT STABILITY TESTS

9A. 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)*

9B. 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)*

9C. 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 X - PATELLAR SUBLUXATION/DISLOCATION

10. 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

SECTION XI - ADDITIONAL CONDITIONS

11. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER HAD "SHIN SPLINTS" *(medial tibial stress syndrome)*, STRESS FRACTURES, CHRONIC EXERTIONAL COMPARTMENT SYNDROME OR ANY OTHER TIBIAL AND/OR FIBULAR IMPAIRMENT?

☐ YES ☐ NO

(If "Yes," indicate condition and complete the appropriate sections below):

☐ A. "SHIN SPLINTS" *(medial tibial stress syndrome)*

(If checked, indicate side affected): ☐ Right ☐ Left ☐ Both

Describe current symptoms: ______________________________

☐ B. STRESS FRACTURE OF THE LOWER EXTREMITY

(If checked, indicate side affected): ☐ Right ☐ Left ☐ Both

Describe current symptoms: ______________________________

☐ C. CHRINIC EXERTIONAL COMPARTMENT SYNDROME

(If checked, indicate side affected): ☐ Right ☐ Left ☐ Both

Describe current symptoms: ______________________________

☐ D. EVIDENCE OF ACQUIRED, TRAUMATIC GENU RECURVATUM WITH WEAKNESS AND INSECURITY IN WEIGHT-BEARING

(If checked, indicate side affected): ☐ Right ☐ Left ☐ Both

☐ E. LEG LENGTH DISCREPANCY *(shortening of any bones of the lower extremity)*

(If checked, provide length of each lower extremity in inches (to the nearest 1/4 inch) or centimeters measuring from the anterior superior iliac spine to the internal malleolus of the tibia.

Measurements: Right leg: ____________ ☐ cm ☐ inches Left leg: ____________ ☐ cm ☐ inches

SECTION XII - MENISCAL CONDITIONS AND MENISCAL SURGERY

12. HAS THE VETERAN HAD ANY MENISCAL CONDITIONS OR SURGICAL PROCEDURES FOR A MENISCAL CONDITION?

☐ YES ☐ NO

(If "Yes," complete the following section):

A. 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

B. HAS THE VETERAN HAD A MENISCECTOMY?

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

Date of surgery: ______________

C. DOES THE VETERAN HAVE ANY RESIDUAL SIGNS AND/OR SYMPTOMS DUE TO A MENISCECTOMY?

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

(If "Yes," describe residuals):

SECTION XIII - JOINT REPLACEMENT AND OTHER SURGICAL PROCEDURES

13A. 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: ______________________________

SECTION XIII - JOINT REPLACEMENT AND OTHER SURGICAL PROCEDURES *(Continued)*

13A. HAS THE VETERAN HAD A TOTAL KNEE JOINT REPLACEMENT? (Continued)

☐ 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: ____________

13B. HAS THE VETERAN HAD ARTHROSCOPIC OR OTHER KNEE SURGERY NOT DESCRIBED ABOVE?

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

Date and type of surgery: ____________

13C. DOES THE VETERAN HAVE ANY RESIDUAL SIGNS AND/OR SYMPTOMS DUE TO ARTHROSCOPIC OR OTHER KNEE SURGERY NOT DESCRIBED ABOVE?

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

(If "Yes," describe symptoms):

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

14A. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO

If "Yes," are any of the scars painful and/or unstable, or is the total area of all related scars greater than 9 square cm (6 square inches)?

☐ YES ☐ NO

(If "Yes," also complete VA Form 21-0960F-1, Scars/Disfigurement Questionnaire)

14B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO *If "Yes," describe (brief summary):*

SECTION XV - ASSISTIVE DEVICES

15A. DOES THE VETERAN USE ANY ASSISTIVE DEVICE(S) 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

15B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION XVI - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

16. DUE TO THE VETERANS KNEE AND/OR LOWER LEG 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 for 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) for which this applies) :

☐ Right lower ☐ Left lower

(For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

SECTION XVII - DIAGNOSTIC TESTING

NOTE: THE DIAGNOSIS OF DEGENERATIVE ARTHRITIS *(osteoarthritis)* OR TRAMATIC ARTHRITIS MUST BE CONFIRMED BY IMAGING STUDIES. ONCE SUCH ARTHRITIS HAS BEEN DOCUMENTED, NO FURTHER IMAGING STUDIES ARE REQUIRED BY VA, EVEN IF ARTHRITIS HAS WORSENED.

17A. HAVE IMAGING STUDIES OF THE KNEE BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

(If "Yes," is degenerative or traumatic arthritis documented?)

☐ YES ☐ NO

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

17B. DOES THE VETERAN HAVE X-RAY EVIDENCE OF PATELLAR SUBLUXATION?

☐ YES ☐ NO

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

17C. 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 XVIII - FUNCTIONAL IMPACT

18. 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 knee and/or lower leg conditions providing one or more examples):*

SECTION XIX - REMARKS

19. REMARKS *(If any)*

SECTION XX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

20A. PHYSICIAN'S SIGNATURE	20B. PHYSICIAN'S PRINTED NAME	20C. DATE SIGNED

20D. PHYSICIAN'S PHONE AND FAX NUMBER	20E. PHYSICIAN'S MEDICAL LICENSE NUMBER	20F. 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.