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

Department of Veterans Affairs

HIP AND THIGH 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

SECTION I - DIAGNOSIS

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.

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER HAD A HIP AND/OR THIGH CONDITION?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO HIP/THIGH 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 PERTAINING TO HIP/THIGH CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S CURRENT HIP/THIGH CONDITION(S) *(Brief summary):*

SECTION III - FLARE-UPS

3. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE HIP AND/OR THIGH?

☐ 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 VISIBLE BEHAVIOR SUCH AS FACIAL EXPRESSION, WINCING, ETC. REPORT INITIAL MEASUREMENTS BELOW.

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 REPTITIONS. REPORT POST-TEST MEASUREMENTS IN SECTION 5.

4A. Right hip flexion

Select where flexion ends (normal endpoint is 125 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 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 or greater

4B. Right hip extension

Select where extension ends:

☐ 0 ☐ 5 ☐ Greater than 5

Select where objective evidence of pain motion begins:

☐ No objective evidence of painful motion
☐ 0 ☐ 5 ☐ Greater than 5

Is abduction lost beyond 10 degrees?

☐ YES ☐ NO

Is adduction limited such that the Veteran cannot cross legs?

☐ YES ☐ NO

Is rotation limited such that the Veteran cannot toe-out more than 15 degrees?

☐ YES ☐ NO

4C. Left hip flexion

Select where flexion ends (normal endpoint is 125 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 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 or greater

4D. Left hip extension

Select where extension ends:

☐ 0 ☐ 5 ☐ Greater than 5

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐ 0 ☐ 5 ☐ Greater than 5

Is abduction lost beyond 10 degrees?

☐ YES ☐ NO

Is adduction limited such that the Veteran cannot cross legs?

☐ YES ☐ NO

Is rotation limited such that the Veteran cannot toe-out more than 15 degrees?

☐ YES ☐ NO

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 hip 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 VI)

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

5B. RIGHT HIP 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 or greater

Select where post-test flexion ends:

☐ 0 ☐ 5 or greater

Is post-test adduction lost beyond 10 degrees?

☐ YES ☐ NO

Is post-test adduction limited such that the veteran cannot cross legs?

☐ YES ☐ NO

Is post-test rotation limited such that the veteran cannot toe-out more than 15 degrees?

☐ YES ☐ NO

5C. LEFT HIP 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 or greater

Select where post-test flexion ends:

☐ 0 ☐ 5 or greater

Is post-test adduction lost beyond 10 degrees?

☐ YES ☐ NO

Is post-test adduction limited such that the veteran cannot cross legs?

☐ YES ☐ NO

Is post-test rotation limited such that the veteran cannot toe-out more than 15 degrees?

☐ YES ☐ NO

SECTION VI - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION IN ROM

NOTE: 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 INABLILITY 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 HIP AND THIGH FOLLOWING REPETITIVE-USE TESTING?

☐ YES ☐ NO

6B. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS AND/OR FUNCTIONAL IMPAIRMENT OF THE HIP AND THIGH?

☐ YES ☐ NO

6C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT AND/OR ADDITIONAL LIMITATION OF ROM OF THE HIP AND THIGH 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 VII - PAIN (PAIN ON PALPATION)

7. DOES THE VETERAN HAVE LOCALIZED TENDERNESS OR PAIN TO PALPATION FOR JOINTS/SOFT TISSUE OF EITHER HIP?

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

SECTION VIII - MUSCLE STRENGTH TESTING

8. RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

0/5 No muscle movement

1/5 Palpable or visible muscle contraction, but no joint movement

2/5 Active movement with gravity eliminated

3/5 Active movement against gravity

4/5 Active movement against some resistance

5/5 Normal strength

Hip 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
Hip abduction:	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
Hip 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 - ANKYLOSIS

9A. DOES THE VETERAN HAVE ANKYLOSIS OF EITHER HIP JOINT?

☐ YES ☐ NO *If "Yes," complete Item 9B)*

9B. INDICATE SEVERITY AND SIDE AFFECTED:

☐ FAVORABLE, IN FLEXION AT AN ANGLE BETWEEN 20 AND 40 DEGREES, AND SLIGHT ADDUCTION OR ABDUCTION

☐ Right ☐ Left ☐ Both

☐ INTERMEDIATE, BETWEEN FAVORABLE AND UNFAVORABLE

☐ Right ☐ Left ☐ Both

☐ UNFAVORABLE, EXTREMELY UNFAVORABLE ANKYLOSIS, FOOT NOT REACHING GROUND, CRUTCHES NEEDED

☐ Right ☐ Left ☐ Both

SECTION X - ADDITIONAL CONDITIONS

10A. DOES THE VETERAN HAVE MALUNION OR NONUNION OF FEMUR, FLAIL HIP JOINT OR LEG LENGTH DISCREPANCY?

☐ YES ☐ NO *(If "Yes," indicate condition and complete the appropriate sections below):*

10B. MALUNION OR NONUNION OF THE FEMUR

☐ If Checked, indicate condition and complete the appropriate sections below.

☐ Malunion with slight hip disability	☐ Right	☐ Left	☐ Both
☐ Malunion with moderate hip disability	☐ Right	☐ Left	☐ Both
☐ Malunion with marked hip disability	☐ Right	☐ Left	☐ Both
☐ Fracture of surgical neck with false joint	☐ Right	☐ Left	☐ Both
☐ Fracture of shaft or neck *(anatomical)*, resulting in nonunion without loose motion; weight-bearing preserved with aid of a brace	☐ Right	☐ Left	☐ Both
☐ Fracture of shaft or neck *(anatomical)*, with nonunion with loose motion; *(spiral or oblique fracture)*	☐ Right	☐ Left	☐ Both

NOTE: If impairment of the femur causes knee disability, also complete VA Form 21-0960M-9, Knee and Lower Leg Conditions Disability Benefits Questionnaire.

10C. FLAIL HIP JOINT

☐ *If "Yes," indicate hip affected:* ☐ Right ☐ Left ☐ Both

10D. 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 XI - JOINT REPLACEMENT AND OTHER SURGICAL PROCEDURES

11A. HAS THE VETERAN HAD A TOTAL HIP JOINT REPLACEMENT?

☐ YES ☐ NO *If "Yes," indicate side and severity of residuals*

☐ Right hip

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 hip

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: _____

11B. HAS THE VETERAN HAD ARTHROSCOPIC OR OTHER HIP SURGERY?

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

Date and type of surgery: _____

11C. DOES THE VETERAN HAVE ANY RESIDUAL SIGNS AND/OR SYMPTOMS DUE TO ARTHROSCOPIC OR OTHER HIP SURGERY?

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

(If "Yes," describe residuals): _____

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

12A. 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 39 square cm (6 square inches)?

☐ YES ☐ NO

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

12B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIANOSIS?

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

SECTION XIII - ASSISTIVE DEVICES

13A. 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

13B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION XIV - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

14A. DUE TO THE VETERAN'S HIP AND/OR THIGH 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 PROTHESES? (*Functions of the upper extremity include grasping, manipulation, etc., while 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 extremities 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 XV - DIAGNOSTIC TESTING

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

15A. HAVE IMAGING STUDIES OF THE HIP BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

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

☐ YES ☐ NO

If "Yes," indicate hip: ☐ Right ☐ Left ☐ Both

15B. 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 XVI - FUNCTIONAL IMPACT AND REMARKS

16. DOES THE VETERAN'S HIP AND/OR THIGH CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *If "Yes," describe the impact of each of the Veteran's hip and/or thigh conditions providing one or more examples:*

17. REMARKS *(If any)*

SECTION XVII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

18A. PHYSICIAN'S SIGNATURE	18B. PHYSICIAN'S PRINTED NAME	18C. DATE SIGNED

18D. PHYSICIAN'S PHONE AND FAX NUMBER	18E. PHYSICIAN'S MEDICAL LICENSE NUMBER	18F. 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.