



## EAR CONDITIONS (INCLUDING VESTIBULAR AND INFECTIOUS 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 BEEN DIAGNOSED WITH AN EAR OR PERIPHERAL VESTIBULAR CONDITION?

YES  NO

1B. IF YES, SELECT THE VETERAN'S CONDITION (*check all that apply*):

- |  |                 |                          |
|--|-----------------|--------------------------|
| <input type="checkbox"/> Meniere's syndrome or endolymphatic hydrops                                   | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Peripheral vestibular disorder  | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Benign Paroxysmal Positional Vertigo ( <i>BPPV</i> )                          | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Chronic otitis externa  | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Chronic suppurative otitis media  | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Chronic nonsuppurative otitis media ( <i>serous otitis media</i> )            | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Mastoiditis   | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Cholesteatoma   | ICD code: _____ | Date of diagnosis: _____ |
| If checked, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed.                          |                 |                          |
| <input type="checkbox"/> Otosclerosis  | ICD code: _____ | Date of diagnosis: _____ |
| If checked, a Hearing Loss and Tinnitus Questionnaire must be completed in lieu of this Questionnaire. |                 |                          |
| <input type="checkbox"/> Benign neoplasm of the ear ( <i>other than skin only</i> )                    | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Malignant neoplasm of the ear ( <i>other than skin only</i> )                 | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> Other, specify:   |                 |                          |
| Other, diagnosis #1: _____   | ICD Code: _____ | Date of Diagnosis: _____ |
| Other, diagnosis #2: _____   | ICD Code: _____ | Date of Diagnosis: _____ |

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO EAR OR PERIPHERAL VESTIBULAR CONDITIONS, LIST USING ABOVE FORMAT:

**NOTE:** If the Veteran has hearing loss or tinnitus attributable to any ear condition listed above, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed.

### SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (*including onset and course*) OF THE VETERAN'S EAR OR PERIPHERAL VESTIBULAR CONDITIONS (*brief summary*):

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITION?

YES  NO

IF YES, LIST ONLY THOSE MEDICATIONS USED FOR THE DIAGNOSED CONDITION:

**SECTION III - VESTIBULAR CONDITIONS**

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING FINDINGS, SIGNS, OR SYMPTOMS ATTRIBUTABLE TO MENIERE'S SYNDROME (*ENDOLYMPHATIC HYDROPS*), A PERIPHERAL VESTIBULAR CONDITION OR ANOTHER DIAGNOSED CONDITION FROM SECTION 1?

YES  NO

IF YES, CHECK ALL THAT APPLY:

Hearing impairment with vertigo

If checked, indicate frequency:  Less than once a month  1 to 4 times per month  More than once weekly

Indicate duration of episodes:  < 1 hour  1 to 24 hours  > 24 hours

Hearing impairment with attacks of vertigo and cerebellar gait

If checked, indicate frequency:  Less than once a month  1 to 4 times per month  More than once weekly

Indicate duration of episodes:  < 1 hour  1 to 24 hours  > 24 hours

Tinnitus, unilateral or bilateral

If checked, indicate frequency:  Less than once a month  1 to 4 times per month  More than once weekly

Indicate duration of episodes:  < 1 hour  1 to 24 hours  > 24 hours

Vertigo

If checked, indicate frequency:  Less than once a month  1 to 4 times per month  More than once weekly

Indicate duration of episodes:  < 1 hour  1 to 24 hours  > 24 hours

Staggering

If checked, indicate frequency:  Less than once a month  1 to 4 times per month  More than once weekly

Indicate duration of episodes:  < 1 hour  1 to 24 hours  > 24 hours

Hearing impairment and/or tinnitus

If checked, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed

Other, describe: \_\_\_\_\_

**SECTION IV - INFECTIOUS, INFLAMMATORY AND OTHER EAR CONDITIONS**

4A. DOES THE VETERAN HAVE ANY OF THE FOLLOWING FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO CHRONIC EAR INFECTION, INFLAMMATION, CHOLESTEATOMA OR ANY OF THE DIAGNOSES IN SECTION 1?

YES  NO

IF YES, CHECK ALL THAT APPLY:

Swelling (*external ear canal*)

If checked, describe: \_\_\_\_\_

Dry and scaly (*external ear canal*)

Serous discharge (*external ear canal*)

Itching (*external ear canal*)

Effusion

Active suppuration

Aural polyps

Hearing impairment and/or tinnitus

If checked, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed.

Facial nerve paralysis

If checked, ALSO complete Cranial Nerves Questionnaire.

Bone loss of skull

If checked, indicate severity:

Area lost smaller than an American quarter (*4.619 cm<sup>2</sup>*)

Area lost larger than an American quarter but smaller than a 50-cent piece

Area lost larger than an American 50-cent piece (*7.355 cm<sup>2</sup>*)

Requiring frequent and prolonged treatment

If checked, describe type and durations of treatment: \_\_\_\_\_

Other, describe: \_\_\_\_\_

4B. DOES THE VETERAN HAVE A BENIGN NEOPLASM OF THE EAR (*other than skin only, such as keloid*) THAT CAUSES ANY IMPAIRMENT OF FUNCTION?

YES  NO

IF YES, DESCRIBE IMPAIRMENT OF FUNCTION CAUSED BY THIS CONDITION:

**SECTION V - SURGICAL TREATMENT**

5A. HAS THE VETERAN HAD SURGICAL TREATMENT FOR ANY EAR CONDITION?

YES  NO IF YES, INDICATE TYPE OF SURGERY:

Date: \_\_\_\_\_ Side affected:  Right  Left  Both

5B. DOES THE VETERAN HAVE ANY RESIDUALS AS A RESULT OF THE SURGERY?

YES  NO IF YES, DESCRIBE:

**SECTION VI - PHYSICAL EXAM**

6A. EXTERNAL EAR:

- Exam or external ear not indicated
- Normal
- Deformity of auricle, with loss of less than one-third of the substance  
If checked, specify side:  Right  Left
- Deformity of auricle, with loss of one-third or more of the substance  
If checked, specify side:  Right  Left
- Complete loss of auricle  
If checked, specify side:  Right  Left
- Other abnormality, describe:  
\_\_\_\_\_

6B. EAR CANAL:

- Exam of ear canal not indicated
- Normal
- Abnormal, describe:  
\_\_\_\_\_

6C. TYMPANIC MEMBRANE:

- Exam of tympanic membrane not indicated
- Normal
- Perforated tympanic membrane  
If checked, specify side affected:  Right  Left
- Evidence of a healed tympanic membrane perforation  
If checked, specify side affected:  Right  Left
- Other abnormality, describe:  
\_\_\_\_\_

6D. GAIT:

- Exam of gait not indicated
- Normal
- Unsteady, describe:  
\_\_\_\_\_
- Other abnormality, describe:  
\_\_\_\_\_

6E. ROMBERG TEST:

- Exam using this test not indicated
- Normal or negative
- Abnormal or positive for unsteadiness

6F. DIX HALLPIKE TEST (*Nylen-Barany test*) FOR VERTIGO:

- Exam using this test not indicated
- Normal, no vertigo or nystagmus during test
- Abnormal, vertigo or nystagmus during test, describe:  
\_\_\_\_\_

6G. LIMB COORDINATION TEST (*finger-nose-finger*):

- Exam using this test not indicated
- Normal
- Abnormal, describe:  
\_\_\_\_\_

**SECTION VII - TUMORS AND NEOPLASMS**

7A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN DIAGNOSIS SECTION 1?

YES  NO

IF YES, COMPLETE THE FOLLOWING:

7B. IS THE NEOPLASM

BENIGN  MALIGNANT

7C. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

YES  NO; WATCHFUL WAITING

IF YES, INDICATE TYPE OF TREATMENT THE VETERAN IS CURRENTLY UNDERGOING OR HAS COMPLETED (*check all that apply*):

Treatment completed; currently in watchful waiting status

Surgery

If checked, describe: \_\_\_\_\_

Date(s) of surgery: \_\_\_\_\_

Radiation therapy

Date of most recent treatment: \_\_\_\_\_

Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

Antineoplastic chemotherapy

Date of most recent treatment: \_\_\_\_\_

Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

Other therapeutic procedure

If checked, describe procedure: \_\_\_\_\_

Date of most recent procedure: \_\_\_\_\_

Other therapeutic treatment

If checked, describe treatment: \_\_\_\_\_

Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

7D. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (*including metastases*) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT ABOVE?

YES  NO

IF YES, LIST RESIDUAL CONDITIONS AND COMPLICATIONS (*brief summary*):

7E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN DIAGNOSIS SECTION 1, DESCRIBE USING THE ABOVE FORMAT:

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

8A. DOES THE VETERAN HAVE ANY SCARS (*surgical or otherwise*) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION 1?

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 A SCARS QUESTIONNAIRE.

8B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN DIAGNOSIS SECTION 1?

YES  NO

IF YES, DESCRIBE (*brief summary*):

**SECTION IX - DIAGNOSTIC TESTING**

**NOTE:** If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report.

9A. HAVE DIAGNOSTIC IMAGING STUDIES OR OTHER DIAGNOSTIC PROCEDURES BEEN PERFORMED?

YES  NO

IF YES, CHECK ALL THAT APPLY:

- Magnetic resonance imaging (MRI) Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Computerized axial tomography (CT) Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Electronystagmography (ENG) Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Other, specify: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

9B. HAS THE VETERAN HAD AN AUDIOGRAM?

YES  NO

IF YES, ATTACH OR PROVIDE RESULTS:

IF THE VETERAN HAS HEARING LOSS OR TINNITUS, A HEARING AND TINNITUS EXAM MUST ALSO BE SCHEDULED.

9C. 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 X - FUNCTIONAL IMPACT**

10. DO ANY OF THE VETERAN'S EAR OR PERIPHERAL VESTIBULAR CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

YES  NO

IF YES, DESCRIBE IMPACT OF EACH OF THE VETERAN'S EAR OR PERIPHERAL VESTIBULAR CONDITIONS, PROVIDING ONE OR MORE EXAMPLES:

**SECTION XI - REMARKS**

11. REMARKS (If any)

**SECTION XII - PHYSICIAN'S CERTIFICATION AND SIGNATURE**

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

12A. PHYSICIAN'S SIGNATURE		12B. PHYSICIAN'S PRINTED NAME	12C. DATE SIGNED
12D. PHYSICIAN'S PHONE AND FAX NUMBER	12E. PHYSICIAN'S MEDICAL LICENSE NUMBER	12F. 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](http://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](http://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.