OMB Control No. 2900-0776
Respondent Burden: 15 minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

TEMPOROMANDIBULAR JOINT (TMJ) 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 OR SHE EVER HAD A TEMPOROMANDIBULAR JOINT CONDITION?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO TEMPOROMANDIBULAR JOINT CONDITIONS:

Diagnosis # 1:	ICD code:	Date of diagnosis:
Diagnosis # 2:	ICD code:	Date of diagnosis:
Diagnosis # 3:	ICD code:	Date of diagnosis:

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO TEMPOROMANDIBULAR JOINT CONDITIONS LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S TEMPOROMANDIBULAR JOINT CONDITION *(Brief summary):*

SECTION III - FLARE-UPS

3. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE TEMPOROMANDIBULAR JOINT?

☐ YES ☐ NO

IF YES, DOCUMENT THE VETERAN'S DESCRIPTION OF THE IMPACT OF FLARE-UPS ON FUNCTION IN HIS OR HER OWN WORDS:

SECTION IV - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS

Measure ROM. 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 repetitions. Report post-test measurements in Section V.

4A. ROM FOR LATERAL EXCURSION:

☐ Greater than 4 mm
☐ 0 to 4 mm

SELECT WHERE EVIDENCE OF PAINFUL MOTION BEGINS:

☐ No objective evidence of painful motion
☐ Greater than 4 mm
☐ 0 to 4 mm

4B. ROM FOR OPENING MOUTH, MEASURED BY INTER-INCISAL DISTANCE:

☐ Greater than 40 mm
☐ 31 to 40 mm
☐ 21 to 30 mm
☐ 11 to 20 mm
☐ 0 to 10 mm

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

4B. ROM FOR OPENING MOUTH, MEASURED BY INTER-INCISAL DISTANCE *(Continued)*

SELECT WHERE OBJECTIVE EVIDENCE OF PAINFUL MOTION BEGINS:

- [ ] No objective evidence of painful motion
- [ ] Greater than 40 mm
- [ ] 31 to 40 mm
- [ ] 21 to 30 mm
- [ ] 11 to 20 mm
- [ ] 0 to 10 mm

4C. IF ROM DOES NOT CONFORM TO THE NORMAL RANGE OF MOTION IDENTIFIED ABOVE BUT IS NORMAL FOR THIS VETERAN *(for reasons other than a temporomandibular joint condition, such as age, body habitus, neurologic disease)*, EXPLAIN:

SECTION V - ROM MEASUREMENT AFTER REPETITIVE USE TESTING

5A. IS THE 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. POST-TEST ROM FOR LATERAL EXCURSION:

- [ ] 0 to 4 mm
- [ ] Greater than 4 mm

5C. POST-TEST ROM FOR OPENING MOUTH, MEASURED BY INTER-INCISAL DISTANCE:

- [ ] Greater than 40 mm
- [ ] 31 to 40 mm
- [ ] 21 to 30 mm
- [ ] 11 to 20 mm
- [ ] 0 to 10 mm

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 EITHER TMJ FOLLOWING REPETITIVE-USE TESTING?

- [ ] YES - [ ] NO

6B. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT OF EITHER TMJ?

- [ ] YES - [ ] NO

6C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT AND/OR ADDITIONAL LIMITATION OF ROM OF EITHER TMJ AFTER REPETITIVE USE, INDICATE THE CONTRIBUTING FACTORS OF DISABILITY BELOW *(Check all that apply and indicate side affected):*

Factor	Side		
[ ] No functional loss for right TMJ	[ ] Right	[ ] Left	[ ] Both
[ ] No functional loss for left TMJ	[ ] Right	[ ] Left	[ ] Both
[ ] Less movement than normal	[ ] Right	[ ] Left	[ ] Both
[ ] More movement than normal	[ ] Right	[ ] Left	[ ] Both
[ ] Weakened movement	[ ] Right	[ ] Left	[ ] Both
[ ] Pain on movement	[ ] Right	[ ] Left	[ ] Both
[ ] Excess fatigability	[ ] Right	[ ] Left	[ ] Both
[ ] Incoordination, impaired ability to execute skilled movements smoothly	[ ] Right	[ ] Left	[ ] Both
[ ] Swelling	[ ] Right	[ ] Left	[ ] Both
[ ] Deformity	[ ] Right	[ ] Left	[ ] Both

SECTION VII - PAIN (PAIN ON PALPATION) AND CREPITUS

7A. DOES THE VETERAN HAVE LOCALIZED TENDERNESS OR PAIN ON PALPATION OF JOINTS OR SOFT TISSUES OF EITHER TMJ?

- [ ] YES - [ ] NO

IF YES, SIDE AFFECTED: [ ] Right [ ] Left [ ] Both

7B. DOES THE VETERAN HAVE CLICKING OR CREPITATION OF JOINTS OR SOFT TISSUES OF EITHER TMJ?

- [ ] YES - [ ] NO

IF YES, SIDE AFFECTED: [ ] Right [ ] Left [ ] Both

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 SECTION I, DIAGNOSIS?

☐ YES ☐ NO

IF YES, ARE ANY OF THE SCARS PAINFUL/OR UNSTABLE, OR IS THE TOTAL AREA OF ALL RELATED SCARS GREATER THAN OR EQUAL TO 39 SQUARE CM *(6 square inches)*?

☐ YES ☐ NO *(f "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)*

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

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

SECTION IX - DIAGNOSTIC TESTING

NOTE: 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 required by VA, even if arthritis has worsened.

9A. HAVE IMAGING STUDIES OF THE TMJ BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, IS DEGENERATIVE OR TRAUMATIC ARTHRITIS DOCUMENTED?

☐ YES ☐ NO

IF YES, SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

9B. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO

IF YES, SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS *(Brief summary)*:

SECTION X - FUNCTIONAL IMPACT

10. DOES THE VETERAN'S TEMPOROMANDIBULAR JOINT CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

IF YES, DESCRIBE THE IMPACT OF EACH OF THE VETERAN'S TEMPOROMANDIBULAR 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.benefits.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 voluntary. 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.