Department of Veterans Affairs

EAR CONDITIONS (INCLUDING VESTIBULAR AND INFECTIOUS CONDITIONS) DISABILITY BENEFITS QUESTIONNAIRE

Name of Patient/Veteran	Patient/Veteran's Social Security Number	Date of examination:

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.

Note - The Veteran 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. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the Veteran's application. VA reserves the right to confirm the authenticity of ALL completed questionnaires. **It is intended that this questionnaire will be completed by the Veteran's healthcare provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

☐ Veteran/Claimant

☐ Third party (please list name(s) of organization(s) or individual(s))

☐ Other: please describe

Are you a VA Healthcare provider? ◯ Yes ◯ No

Is the Veteran regularly seen as a patient in your clinic? ◯ Yes ◯ No

Was the Veteran examined in person? ◯ Yes ◯ No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

◯ No records were reviewed

◯ Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

SECTION I - DIAGNOSIS

Note: These are condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. List the claimed condition(s) that pertain to this questionnaire:

Note: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition(s), explain your findings and reasons in the comments section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis or an approximate date determined through record review or reported history.

Note: If the Veteran reports hearing loss or tinnitus attributable to any ear condition listed below, a Hearing Loss and Tinnitus Questionnaire must also be completed.

1B. Select diagnoses associated with the claimed condition(s) (check all that apply):

☐ The Veteran does not have a current diagnosis associated with any claimed condition(s) listed above. (Explain your findings and reasons in the comments section)

☐ Meniere's syndrome or endolymphatic hydrops ICD Code: _____ Date of diagnosis: _____

☐ Peripheral vestibular disorder ICD Code: _____ Date of diagnosis: _____

☐ Benign Paroxysmal Positional Vertigo (BPPV) ICD Code: _____ Date of diagnosis: _____

☐ Chronic otitis externa ICD Code: _____ Date of diagnosis: _____

☐ Chronic suppurative otitis media ICD Code: _____ Date of diagnosis: _____

☐ Chronic nonsuppurative otitis media (serous otitis media) ICD Code: _____ Date of diagnosis: _____

☐ Mastoiditis ICD Code: _____ Date of diagnosis: _____

☐ Cholesteatoma ICD Code: _____ Date of diagnosis: _____

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

☐ Otosclerosis ICD Code: _____ Date of diagnosis: _____

If checked, a Hearing Loss and Tinnitus Questionnaire must be completed in lieu of this Questionnaire

☐ Benign neoplasm of the ear (other than skin only) ICD Code: _____ Date of diagnosis: _____

☐ Malignant neoplasm of the ear (other than skin only) ICD Code: _____ Date of diagnosis: _____

☐ Other, specify:

Other, diagnosis #1: _____ ICD Code: _____ Date of diagnosis: _____

Other, diagnosis #2: _____ ICD Code: _____ Date of diagnosis: _____

Other, diagnosis #3: _____ 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, course, and treatment) 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

3A. 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 I?

◯ 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 listed in Section I?

◯ 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 cm2)

◯ 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 cm2)

☐ 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:

Type of surgery: _____

Date of surgery: _____ 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 of 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 the diagnosis section?

◯ Yes ◯ No If yes, complete the following:

7B. Is the neoplasm:

◯ Benign

◯ Malignant

◯ Active ◯ In remission

◯ Primary ◯ Secondary (metastatic) (if secondary, indicate the primary site, if known): _____

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 the diagnosis section, describe using the above format:

SECTION VIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

8A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to the conditions listed in the diagnosis section above?

◯ Yes ◯ No If yes, describe (brief summary):

8B. Does the Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis section?

◯ Yes ◯ No If yes, also complete the appropriate dermatological questionnaire.

8C. Comments, if any:

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:

Note: If the Veteran has hearing loss or tinnitus, a hearing loss or tinnitus exam must also be completed.

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

10A. 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

11A. Remarks (if any)

SECTION XII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

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.

12A. Examiner's signature:	12B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):	
12C. Examiner's area of practice/specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):		12D. Date signed:
12E. Examiner's phone/fax numbers:	12F. National Provider Identifier (NPI) number:	12G. Medical license number and state:
12H. Examiner's address:		