

ANKLE 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 Remarks 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.

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 Remarks section)

	Side affected:	ICD code:	Date of diagnosis:
<input type="checkbox"/> Lateral collateral ligament sprain (chronic/recurrent)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Deltoid ligament sprain (chronic/recurrent)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Osteochondritis dissecans to include osteochondral fracture	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Impingement (anterior/posterior (or trigonum syndrome)/anterolateral)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Tendonitis (Achilles/peroneal/posterior tibial)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Retrocalcaneal bursitis	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Achilles' tendon rupture	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Avascular necrosis, talus	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Ankle joint replacement	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Ankylosis of ankle, subtalar or tarsal joint	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Medial tibial stress syndrome (MTSS), or shin splints	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Degenerative arthritis, other than post-traumatic	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, gonorrheal	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, pneumococcic	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, streptococcic	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, syphilitic	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, rheumatoid (multi-joints)	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, post-traumatic	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Arthritis, typhoid	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Other specified forms of arthropathy (excluding gout): _____	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Osteoporosis, residuals of	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Osteomalacia, residuals of	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Bones, neoplasm, benign	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Bones, neoplasm, malignant, primary or secondary	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Osteitis deformans	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Gout	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Bursitis	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Myositis	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____
<input type="checkbox"/> Heterotopic ossification	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both		Right: _____ Left: _____

<input type="checkbox"/> Tendinopathy (select one if known)	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
<input type="checkbox"/> Tendinitis	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
<input type="checkbox"/> Tendinosis	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
<input type="checkbox"/> Tenosynovitis	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Both	Right: _____	Left: _____
<input type="checkbox"/> Other (specify): _____					
Other diagnosis #1: _____					
<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both    Right: _____ Left: _____					
Other diagnosis #2: _____					
<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both    Right: _____ Left: _____					
Other diagnosis #3: _____					
<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both    Right: _____ Left: _____					

1C. If there are additional diagnoses that pertain to ankle conditions, list using above format:

_____
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## SECTION II - MEDICAL HISTORY

2A. Describe the history, including onset and course, of the Veteran's ankle condition(s). Brief summary:

_____
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2B. Does the Veteran report flare-ups of the ankle?

Yes     No

If yes, document the Veteran's description of the flare-ups he/she experiences, including the frequency, duration, characteristics, precipitating and alleviating factors, severity, and/or extent of functional impairment he/she experiences during a flare-up of symptoms:

_____
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2C. Does the Veteran report having any functional loss or functional impairment of the joint or extremity being evaluated on this questionnaire, including but not limited to after repeated use over time?

Yes     No

If yes, document the Veteran's description of functional loss or functional impairment in his/her own words:

2D. Does the Veteran report or have a history of instability of the ankle?

Yes     No

If yes, document the Veteran's description of instability in his/her own words:

### SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION

There are several separate parameters requested for describing function of a joint. The question "Does this ROM contribute to a functional loss?" asks if there is a functional loss that can be ascribed to any documented loss of range of motion; and, unlike later questions, does not take into account the numerous other factors to be considered. Subsequent questions take into account additional factors such as pain, fatigue, weakness, lack of endurance, or incoordination. If there is pain noted on examination, it is important to understand whether or not that pain itself contributes to functional loss. Ideally, a claimant would be seen immediately after repetitive use over time or during a flare-up; however, this is not always feasible.

Information regarding joint function on repetitive use is broken up into two subsets. The first subset is based on observed repetitive use, and the second is based on functional loss associated with repeated use over time. The observed repetitive use section initially asks for objective findings after three or more repetitions of range of motion testing. The second subset provides a more global picture of functional loss associated with repetitive use over time. The latter takes into account medical probability of additional functional loss as a global view. This takes into account not only the objective findings noted on the examination, but also the subjective history provided by the claimant, as well as review of the available medical evidence.

Optimally, a description of any additional loss of function should be provided - such as what the degrees of range of motion would be opined to look like after repetitive use over time. However, when this is not feasible, an "as clear as possible" description of that loss should be provided. This same information (minus the three repetitions) is asked to be provided with regards to flare-ups.

RIGHT ANKLE	LEFT ANKLE
<p>3A. Initial ROM measurements</p> <p><input type="radio"/> All Normal      <input type="radio"/> Abnormal or outside of normal range <input type="radio"/> Unable to test      <input type="radio"/> Not indicated</p>	<p>3A. Initial ROM measurements</p> <p><input type="radio"/> All Normal      <input type="radio"/> Abnormal or outside of normal range <input type="radio"/> Unable to test      <input type="radio"/> Not indicated</p>
<p>If "Unable to test" or "Not indicated", please explain:</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>	
<p>If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than an ankle condition, such as age, body habitus, neurologic disease), please describe:</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>	

If abnormal, does the range of motion itself contribute to a functional loss? <input type="radio"/> Yes <input type="radio"/> No	If abnormal, does the range of motion itself contribute to a functional loss? <input type="radio"/> Yes <input type="radio"/> No
If yes, please explain: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	If yes, please explain: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>

Note: For any joint condition, examiners should address pain on both passive and active motion, and on both weight-bearing and nonweight-bearing. Examiners should also test the contralateral joint (unless medically contraindicated). If testing cannot be performed or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation must be given below. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).

Can testing be performed? <input type="radio"/> Yes <input type="radio"/> No	Can testing be performed? <input type="radio"/> Yes <input type="radio"/> No
If no, provide an explanation: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	If no, provide an explanation: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>

If this is the unclaimed joint, is it: <input type="radio"/> Damaged <input type="radio"/> Undamaged	If this is the unclaimed joint, is it: <input type="radio"/> Damaged <input type="radio"/> Undamaged
If undamaged, range of motion testing must be conducted.	
Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values.	
Plantar flexion endpoint (45 degrees):    _____ degrees	Plantar flexion endpoint (45 degrees):    _____ degrees
Dorsiflexion endpoint (20 degrees):    _____ degrees	Dorsiflexion endpoint (20 degrees):    _____ degrees
If noted on examination, which ROM exhibited pain (select all that apply):	
<input type="checkbox"/> Plantar flexion <input type="checkbox"/> Dorsiflexion	<input type="checkbox"/> Plantar flexion <input type="checkbox"/> Dorsiflexion
If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.	
Plantar flexion degree endpoint (if different than above) _____	Plantar flexion degree endpoint (if different than above) _____
Dorsiflexion degree endpoint (if different than above) _____	Dorsiflexion degree endpoint (if different than above) _____
<div style="border: 1px solid black; height: 100px; width: 100%;"></div>	

Passive Range of Motion - Perform passive range of motion and provide the ROM values.	
Plantar flexion endpoint (45 degrees):    _____ degrees	<input type="checkbox"/> Same as active ROM
Dorsiflexion endpoint (20 degrees):    _____ degrees	<input type="checkbox"/> Same as active ROM
Passive Range of Motion - Perform passive range of motion and provide the ROM values.	
Plantar flexion endpoint (45 degrees):    _____ degrees	<input type="checkbox"/> Same as active ROM
Dorsiflexion endpoint (20 degrees):    _____ degrees	<input type="checkbox"/> Same as active ROM

<p>If noted on examination, which passive ROM exhibited pain (select all that apply):</p> <p><input type="checkbox"/> Plantar flexion      <input type="checkbox"/> Dorsiflexion</p> <p>If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.</p> <p>Plantar flexion degree endpoint (if different than above) _____</p> <p>Dorsiflexion degree endpoint (if different than above) _____</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>	<p>If noted on examination, which passive ROM exhibited pain (select all that apply):</p> <p><input type="checkbox"/> Plantar flexion      <input type="checkbox"/> Dorsiflexion</p> <p>If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.</p> <p>Plantar flexion degree endpoint (if different than above) _____</p> <p>Dorsiflexion degree endpoint (if different than above) _____</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>
<p>Is there evidence of pain?      <input type="radio"/> Yes      <input type="radio"/> No</p> <p>If yes, check all that apply.</p> <p><input type="checkbox"/> Weight-bearing      <input type="checkbox"/> Nonweight-bearing</p> <p><input type="checkbox"/> Active motion      <input type="checkbox"/> Passive motion      <input type="checkbox"/> On rest/non-movement</p> <p><input type="checkbox"/> Causes functional loss (if checked describe in the comments box below)</p> <p><input type="checkbox"/> Does not result in/cause functional loss</p> <p>Comments: <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>	<p>Is there evidence of pain?      <input type="radio"/> Yes      <input type="radio"/> No</p> <p>If yes, check all that apply.</p> <p><input type="checkbox"/> Weight-bearing      <input type="checkbox"/> Nonweight-bearing</p> <p><input type="checkbox"/> Active motion      <input type="checkbox"/> Passive motion      <input type="checkbox"/> On rest/non-movement</p> <p><input type="checkbox"/> Causes functional loss (if checked describe in the comments box below)</p> <p><input type="checkbox"/> Does not result in/cause functional loss</p> <p>Comments: <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>
<p>Is there objective evidence of crepitus?      <input type="radio"/> Yes      <input type="radio"/> No</p> <p>Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?</p> <p><input type="radio"/> Yes      <input type="radio"/> No</p> <p>If yes, please explain. Include location, severity, and relationship to condition(s). <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>	<p>Is there objective evidence of crepitus?      <input type="radio"/> Yes      <input type="radio"/> No</p> <p>Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?</p> <p><input type="radio"/> Yes      <input type="radio"/> No</p> <p>If yes, please explain. Include location, severity, and relationship to condition(s). <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>
<p>3B. Observed repetitive use ROM</p> <p>Is the Veteran able to perform repetitive-use testing with at least three repetitions?</p> <p><input type="radio"/> Yes      <input type="radio"/> No</p>	<p>3B. Observed repetitive use ROM</p> <p>Is the Veteran able to perform repetitive-use testing with at least three repetitions?</p> <p><input type="radio"/> Yes      <input type="radio"/> No</p>

<p>If no, please explain:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	<p>If no, please explain:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
<p>Is there additional loss of function or range of motion after three repetitions?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>If yes, please respond to the following after the completion of the three repetitions:</p> <p>Plantar flexion endpoint (45 degrees): _____ degrees</p> <p>Dorsiflexion endpoint (20 degrees): _____ degrees</p> <p>Select factors that cause this functional loss. Check all that apply.</p> <p><input type="checkbox"/> Pain    <input type="checkbox"/> Fatigability    <input type="checkbox"/> Weakness    <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination    <input type="checkbox"/> Other: _____    <input type="checkbox"/> N/A</p>	
<p>Is there additional loss of function or range of motion after three repetitions?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>If yes, please respond to the following after the completion of the three repetitions:</p> <p>Plantar flexion endpoint (45 degrees): _____ degrees</p> <p>Dorsiflexion endpoint (20 degrees): _____ degrees</p> <p>Select factors that cause this functional loss. Check all that apply.</p> <p><input type="checkbox"/> Pain    <input type="checkbox"/> Fatigability    <input type="checkbox"/> Weakness    <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination    <input type="checkbox"/> Other: _____    <input type="checkbox"/> N/A</p>	
<p>Note: When pain is associated with movement, the examiner must give a statement on whether pain could significantly limit functional ability during flare-ups and/or after repeated use over time in terms of additional loss of range of motion. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare-ups - even if not directly observed during a flare-up and/or after repeated use over time.</p>	
<p>3C. Repeated use over time</p> <p>Is the Veteran being examined immediately after repeated use over time?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>Select factors that cause this functional loss. Check all that apply.</p> <p><input type="checkbox"/> Pain    <input type="checkbox"/> Fatigability    <input type="checkbox"/> Weakness    <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination    <input type="checkbox"/> Other: _____    <input type="checkbox"/> N/A</p> <p>Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran.</p> <p>Plantar flexion endpoint (45 degrees): _____ degrees</p> <p>Dorsiflexion endpoint (20 degrees): _____ degrees</p> <p>The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.</p> <p>Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	<p>3C. Repeated use over time</p> <p>Is the Veteran being examined immediately after repeated use over time?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>Select factors that cause this functional loss. Check all that apply.</p> <p><input type="checkbox"/> Pain    <input type="checkbox"/> Fatigability    <input type="checkbox"/> Weakness    <input type="checkbox"/> Lack of endurance</p> <p><input type="checkbox"/> Incoordination    <input type="checkbox"/> Other: _____    <input type="checkbox"/> N/A</p> <p>Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran.</p> <p>Plantar flexion endpoint (45 degrees): _____ degrees</p> <p>Dorsiflexion endpoint (20 degrees): _____ degrees</p> <p>The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.</p> <p>Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>

**3D. Flare-ups**

Is the examination being conducted during a flare-up?

Yes     No

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare-ups?

Yes     No

Select factors that cause this functional loss. Check all that apply.

Pain     Fatigability     Weakness     Lack of endurance  
 Incoordination     Other: \_\_\_\_\_     N/A

Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran.

Plantar flexion endpoint (45 degrees): \_\_\_\_\_ degrees

Dorsiflexion endpoint (20 degrees): \_\_\_\_\_ degrees

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)

**3E. Additional factors contributing to disability**

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:

None     Interference with sitting  
 Interference with standing     Swelling  
 Disturbance of locomotion     Deformity  
 Less movement than normal     More movement than normal  
 Weakened movement     Atrophy of disuse  
 Instability of station  
 Other, describe: \_\_\_\_\_

Please describe additional contributing factors of disability:

**3D. Flare-ups**

Is the examination being conducted during a flare-up?

Yes     No

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare-ups?

Yes     No

Select factors that cause this functional loss. Check all that apply.

Pain     Fatigability     Weakness     Lack of endurance  
 Incoordination     Other: \_\_\_\_\_     N/A

Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran.

Plantar flexion endpoint (45 degrees): \_\_\_\_\_ degrees

Dorsiflexion endpoint (20 degrees): \_\_\_\_\_ degrees

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence.)

**3E. Additional factors contributing to disability**

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:

None     Interference with sitting  
 Interference with standing     Swelling  
 Disturbance of locomotion     Deformity  
 Less movement than normal     More movement than normal  
 Weakened movement     Atrophy of disuse  
 Instability of station  
 Other, describe: \_\_\_\_\_

Please describe additional contributing factors of disability:

#### SECTION IV - MUSCLE ATROPHY

<p>4A. Does the Veteran have muscle atrophy?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>If no, provide rationale:</p> <div style="border: 1px solid black; height: 150px; margin-top: 10px;"></div>	<p>4A. Does the Veteran have muscle atrophy?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>If no, provide rationale:</p> <div style="border: 1px solid black; height: 150px; margin-top: 10px;"></div>
<p>4C. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.</p> <p><input type="checkbox"/> Right lower extremity (specify location of measurement such as "1cm above or below ankle"):</p> <div style="border: 1px solid black; height: 150px; margin-top: 10px;"></div> <p>Circumference of more normal side: _____ cm</p> <p>Circumference of atrophied side: _____ cm</p>	
<p>4C. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.</p> <p><input type="checkbox"/> Left lower extremity (specify location of measurement such as "1cm above or below ankle"):</p> <div style="border: 1px solid black; height: 150px; margin-top: 10px;"></div> <p>Circumference of more normal side: _____ cm</p> <p>Circumference of atrophied side: _____ cm</p>	

#### SECTION V- ANKYLOSIS

Note: Ankylosis is the immobilization of a joint due to disease, injury or surgical procedure.

<p>5A. Is there ankylosis of the ankle?    <input type="radio"/> Yes    <input type="radio"/> No</p> <p>If yes, indicate the severity of ankle ankylosis:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> In plantar flexion, less than 30 degrees</li> <li><input type="checkbox"/> In plantar flexion, between 30 degrees and 40 degrees</li> <li><input type="checkbox"/> In plantar flexion at more than 40 degrees</li> <li><input type="checkbox"/> In dorsiflexion, between 0 degrees and 10 degree</li> <li><input type="checkbox"/> In dorsiflexion at more than 10 degrees</li> <li><input type="checkbox"/> With an abduction deformity</li> <li><input type="checkbox"/> With an adduction deformity</li> <li><input type="checkbox"/> With an inversion deformity</li> <li><input type="checkbox"/> With an eversion deformity</li> </ul>	<p>5A. Is there ankylosis of the ankle?    <input type="radio"/> Yes    <input type="radio"/> No</p> <p>If yes, indicate the severity of ankle ankylosis:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> In plantar flexion, less than 30 degrees</li> <li><input type="checkbox"/> In plantar flexion, between 30 degrees and 40 degrees</li> <li><input type="checkbox"/> In plantar flexion at more than 40 degrees</li> <li><input type="checkbox"/> In dorsiflexion, between 0 degrees and 10 degree</li> <li><input type="checkbox"/> In dorsiflexion at more than 10 degrees</li> <li><input type="checkbox"/> With an abduction deformity</li> <li><input type="checkbox"/> With an adduction deformity</li> <li><input type="checkbox"/> With an inversion deformity</li> <li><input type="checkbox"/> With an eversion deformity</li> </ul>
<p>5B. Indicate angle of ankle ankylosis in    <input type="checkbox"/> N/A no ankle ankylosis of joint degrees.</p> <p>Plantar flexion: _____</p> <p>Dorsiflexion: _____</p>	
<p>5B. Indicate angle of ankle ankylosis in    <input type="checkbox"/> N/A no ankle ankylosis of joint degrees.</p> <p>Plantar flexion: _____</p> <p>Dorsiflexion: _____</p>	

<p>5C. Is there ankylosis of the subastragalar or tarsal joint?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    If yes, indicate severity:</p> <p><input type="radio"/> In good weight-bearing position <input type="radio"/> In poor weight-bearing position</p>	<p>5C. Is there ankylosis of the subastragalar or tarsal joint?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    If yes, indicate severity:</p> <p><input type="radio"/> In good weight-bearing position <input type="radio"/> In poor weight-bearing position</p>
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#### SECTION VI - JOINT STABILITY

<p>6A. Complete the following:</p> <p>Anterior Drawer Test: Is there absence of firm end point with asymmetric or excessive motion?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> Unable to test</p> <p>Talar Tilt Test: Is there asymmetric or excessive motion?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> Unable to test</p> <p>If unable to test, please explain why:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>	<p>6A. Complete the following:</p> <p>Anterior Drawer Test: Is there absence of firm end point with asymmetric or excessive motion?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> Unable to test</p> <p>Talar Tilt Test: Is there asymmetric or excessive motion?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> Unable to test</p> <p>If unable to test, please explain why:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>
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<p>6B. If unable to test, is ankle instability suspected?    <input type="radio"/> Yes    <input type="radio"/> No</p> <p>If yes, please describe:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>	<p>6B. If unable to test, is ankle instability suspected?    <input type="radio"/> Yes    <input type="radio"/> No</p> <p>If yes, please describe:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>
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#### SECTION VII - ADDITIONAL COMMENTS

<p>7A. Does the Veteran now have or has he or she ever had shin splints (medial tibial stress syndrome), stress fractures, Achilles tendonitis, Achilles tendon rupture, malunion of calcaneus (os calcis) or talus (astragalus), or has the Veteran had a talectomy (astragalectomy)?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>If yes, indicate condition and complete the appropriate sections below:</p> <p><input type="checkbox"/> Stress fracture of the lower leg (If this affects ROM of the knee, please complete the appropriate musculoskeletal questionnaire and ROM section)</p> <p>Describe current symptoms:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p> <p><input type="checkbox"/> Achilles tendonitis or Achilles tendon rupture</p> <p>Describe current symptoms:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>	<p>7A. Does the Veteran now have or has he or she ever had shin splints (medial tibial stress syndrome), stress fractures, Achilles tendonitis, Achilles tendon rupture, malunion of calcaneus (os calcis) or talus (astragalus), or has the Veteran had a talectomy (astragalectomy)?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p> <p>If yes, indicate condition and complete the appropriate sections below:</p> <p><input type="checkbox"/> Stress fracture of the lower leg (If this affects ROM of the knee, please complete the appropriate musculoskeletal questionnaire and ROM section)</p> <p>Describe current symptoms:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p> <p><input type="checkbox"/> Achilles tendonitis or Achilles tendon rupture</p> <p>Describe current symptoms:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div></p>
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<p><input type="checkbox"/> Malunion of calcaneus (os calcis) or talus (astragalus)</p> <p>Indicate severity:</p> <ul style="list-style-type: none"> <li><input type="radio"/> Moderate deformity</li> <li><input type="radio"/> Marked deformity</li> </ul> <p><input type="checkbox"/> "Shin Splints" (medial tibial stress syndrome - MTSS)</p> <p>Indicate all treatment and symptoms below:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Treatment for less than 12 consecutive months</li> <li><input type="checkbox"/> Unresponsive to shoe orthotics or other conservative treatment</li> <li><input type="checkbox"/> Requiring treatment for 12 consecutive months or more</li> <li><input type="checkbox"/> Responsive to surgery</li> <li><input type="checkbox"/> Unresponsive to surgery</li> </ul> <p>Does this condition affect ROM of knee?</p> <ul style="list-style-type: none"> <li><input type="radio"/> Yes (If yes, complete the Knee and Lower Leg Conditions questionnaire)</li> <li><input type="radio"/> No</li> </ul> <p>Describe current symptoms:</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div> <p><input type="checkbox"/> Talectomy</p> <p>Describe current symptoms:</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>	<p><input type="checkbox"/> Malunion of calcaneus (os calcis) or talus (astragalus)</p> <p>Indicate severity:</p> <ul style="list-style-type: none"> <li><input type="radio"/> Moderate deformity</li> <li><input type="radio"/> Marked deformity</li> </ul> <p><input type="checkbox"/> "Shin Splints" (medial tibial stress syndrome - MTSS)</p> <p>Indicate all treatment and symptoms below:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Treatment for less than 12 consecutive months</li> <li><input type="checkbox"/> Unresponsive to shoe orthotics or other conservative treatment</li> <li><input type="checkbox"/> Requiring treatment for 12 consecutive months or more</li> <li><input type="checkbox"/> Responsive to surgery</li> <li><input type="checkbox"/> Unresponsive to surgery</li> </ul> <p>Does this condition affect ROM of knee?</p> <ul style="list-style-type: none"> <li><input type="radio"/> Yes (If yes, complete the Knee and Lower Leg Conditions questionnaire)</li> <li><input type="radio"/> No</li> </ul> <p>Describe current symptoms:</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div> <p><input type="checkbox"/> Talectomy</p> <p>Describe current symptoms:</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>
<b>SECTION VIII - SURGICAL PROCEDURES</b>	
<p>8A. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No surgery</li> <li><input type="checkbox"/> Total ankle joint replacement</li> </ul> <p>Date of surgery: _____</p> <p>Residuals:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Intermediate degrees of residual weakness, pain or limitation of motion</li> <li><input type="checkbox"/> Chronic residuals consisting of severe painful motion or weakness</li> <li><input type="checkbox"/> Other, describe: <div style="border: 1px solid black; height: 80px; width: 100%;"></div></li> </ul>	
<p>8A. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No surgery</li> <li><input type="checkbox"/> Total ankle joint replacement</li> </ul> <p>Date of surgery: _____</p> <p>Residuals:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Intermediate degrees of residual weakness, pain or limitation of motion</li> <li><input type="checkbox"/> Chronic residuals consisting of severe painful motion or weakness</li> <li><input type="checkbox"/> Other, describe: <div style="border: 1px solid black; height: 80px; width: 100%;"></div></li> </ul>	

<input type="checkbox"/> Arthroscopic or other ankle surgery	<input type="checkbox"/> Arthroscopic or other ankle surgery
Type of surgery: _____	Type of surgery: _____
Date of surgery: _____	Date of surgery: _____
<input type="checkbox"/> Residuals of arthroscopic or other ankle surgery	<input type="checkbox"/> Residuals of arthroscopic or other ankle surgery
Describe residuals:	Describe residuals:

#### **SECTION IX - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS**

9A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the diagnosis section above?

Yes       No

If yes, describe (brief summary):

9B. 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.

#### **SECTION X- ASSISTIVE DEVICES**

10A. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible?

Yes       No

If yes, identify the assistive devices used (check all that apply and indicate frequency):

- |                                       |                   |                                  |                                |
|---------------------------------------|-------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> Wheelchair   | Frequency of use: | <input type="radio"/> Occasional | <input type="radio"/> Regular  |
| <input type="checkbox"/> Brace(s)     | Frequency of use: | <input type="radio"/> Occasional | <input type="radio"/> Regular  |
| <input type="checkbox"/> Crutch(es)   | Frequency of use: | <input type="radio"/> Occasional | <input type="radio"/> Regular  |
| <input type="checkbox"/> Cane(s)      | Frequency of use: | <input type="radio"/> Occasional | <input type="radio"/> Regular  |
| <input type="checkbox"/> Walker       | Frequency of use: | <input type="radio"/> Occasional | <input type="radio"/> Regular  |
| <input type="checkbox"/> Other: _____ | Frequency of use: | <input type="radio"/> Occasional | <input type="radio"/> Regular  |
|                                       |                   | <input type="radio"/> Regular    | <input type="radio"/> Constant |
|                                       |                   | <input type="radio"/> Regular    | <input type="radio"/> Constant |
|                                       |                   | <input type="radio"/> Regular    | <input type="radio"/> Constant |
|                                       |                   | <input type="radio"/> Regular    | <input type="radio"/> Constant |

10B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

## SECTION XI - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

Note: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prosthesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

11A. Due to the Veterans ankle 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 of 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

11B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

## SECTION XII - DIAGNOSTIC TESTING

Note: Testing listed below is not indicated for every condition. The diagnosis of degenerative arthritis (osteoarthritis) or post-traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, even if in the past, no further imaging studies are required by VA, even if arthritis has worsened.

12A. Have imaging studies been performed in conjunction with this examination?  Yes  No

12B. If yes, is degenerative or post-traumatic arthritis documented?  Yes  No

If yes, indicate side:  Right  Left  Both

12C. If yes, provide type of test or procedure, date and results (brief summary):

12D. Are there any other significant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

Yes  No

If yes, provide type of test or procedure, date and results (brief summary):

12E. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

### SECTION XIII - FUNCTIONAL IMPACT

Note: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

13A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?

Yes     No

If yes, describe the functional impact of each condition, providing one or more examples:

### SECTION XIV - REMARKS

14A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

### SECTION XV - 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.

15A. Examiner's signature:

15B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

15C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

15D. Date Signed:

15E. Examiner's phone/fax numbers:

15F. National Provider Identifier (NPI) number:

15G. Medical license number and state:

15H. Examiner's address: