Department of Veterans Affairs

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.

Is this questionnaire being completed in conjunction with a VA 21-2507, C&P examination request? ☐ Yes ☐ No

How was the examination completed? Check all that apply:

☐ In-person examination

☐ Records reviewed Comments:

☐ Examination via approved telehealth

☐ Other, please specify in comments box:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

EVIDENCE REVIEWED *(check all that apply):*

☐ Not requested ☐ No records were reviewed

☐ VA claims file (hard copy paper C-file)

☐ VA e-folder (VBMS or Virtual VA)

☐ CPRS

☐ Other (please identify other evidence reviewed):

EVIDENCE COMMENTS:

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN EAR OR PERIPHERAL VESTIBULAR CONDITION?

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

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

☐	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 *If, checked, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed*	ICD code: _____	Date of diagnosis: _____
☐	Otosclerosis *If, checked, a Hearing Loss and Tinnitus Questionnaire must be completed in lieu of this Questionnaire.*	ICD code: _____	Date of diagnosis: _____
☐	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: _____

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 LISTED 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 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:

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 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

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 (*surgical or otherwise*) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

IF YES, ARE ANY OF THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM *(6 square inches)*; OR ARE LOCATED ON THE HEAD, FACE OR NECK? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

☐ YES ☐ NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION: _____ MEASUREMENTS: length _____ cm X width _____ cm.

NOTE: If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

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

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. NATIONAL PROVIDER IDENTIFIER (NPI) 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.

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 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**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.