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EYE 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 ON REVERSE 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. This report is not for treatment purposes; it is to provide a summary of medical information for disability claims resolution. VA reserves the right to confirm the authenticity of ALL DBQ's completed by private health care providers.

NOTE: This examination must be conducted by a licensed ophthalmologist or by a licensed optometrist. The examiner must identify the disease, injury or other pathologic process responsible for any decrease in visual acuity or other visual impairment found. Examinations of visual fields or muscle function should be conducted ONLY when there is a medical indication of disease or injury that may be associated with visual field defect or impaired muscle function. Unless medically contraindicated, the funds must be examined with the veteran's pupils dilated.

SECTION I - DIAGNOSIS

NOTE: The diagnosis section should be filled out AFTER the clinician has completed the examination.

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN EYE CONDITION *(other than congenital or developmental errors of refraction)*?

☐ YES ☐ NO *(If "Yes," provide only diagnosis that pertain to eye conditions:)*

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1B. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO EYE CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

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

SECTION III - PHYSICAL EXAMINATION

1. VISUAL ACUITY

Visual acuity should be reported according to the lines on the Snellen chart or its equivalent. If assessment of the veteran's visual acuity falls between two lines on the Snellen chart, round up to the higher (worse) level (poorer vision) for answers a-d below. (For example, 20/60 would be reported as 20/70; 20/80 would be reported as 20/100. etc.)

Examination of visual acuity must include central uncorrected and corrected visual acuity for distance and near vision. Evaluate visual acuity on the basis of corrected distance vision with central fixation. Visual acuity should not be determined with eccentric fixation or viewing.

a. Uncorrected distance:

RIGHT: ☐ 5/200 ☐ 20/400 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better
LEFT: ☐ 5/200 ☐ 20/400 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

b. Uncorrected near:

RIGHT: ☐ 5/200 ☐ 20/400 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better
LEFT: ☐ 5/200 ☐ 20/400 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

c. Corrected distance:

RIGHT: ☐ 5/200 ☐ 20/400 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better
LEFT: ☐ 5/200 ☐ 20/400 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

d. Corrected near:

RIGHT: ☐ 5/200 ☐ 20/400 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better
LEFT: ☐ 5/200 ☐ 20/400 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

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SECTION III - PHYSICAL EXAMINATION *(Continued)*

2. DIFFERENCE IN CORRECTED VISUAL ACUITY FOR DISTANCE AND NEAR VISION
Does the veteran have a difference equal to two or more lines on the Snellen test type chart or its equivalent between distance and near corrected vision, with the near vision being worse?

☐ Yes ☐ No *(If "Yes," complete Items 2A thru 2C)*

a. Provide a second recording of corrected distance and near vision

Second recording of corrected distance vision:

RIGHT: ☐ 5/200 ☐ 20/400 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

LEFT: ☐ 5/200 ☐ 20/400 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

Second recording of corrected near vision:

RIGHT: ☐ 5/200 ☐ 20/400 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

LEFT: ☐ 5/200 ☐ 20/400 ☐ 15/200 ☐ 20/200 ☐ 20/100 ☐ 20/70 ☐ 20/50 ☐ 20/40 or better

b. Explain reason for the difference between distance and near corrected vision

c. Does the lens required to correct distance vision in the poorer eye differ by more than 3 diopters from the lens required to correct distance vision in the better eye?

☐ Yes ☐ No *(If "Yes," explain reason for the difference)*

3. PUPILS

a. Pupil diameter: Right: ________ mm Left: ________ mm

b. Pupils are round and reactive to light? ☐ Yes ☐ No

c. Is an afferent papillar defect present? ☐ Yes ☐ No

(If "Yes," indicate eye(s)) ☐ Right ☐ Left ☐ Both

d. Other, describe: ____________________

Eyes affected ☐ Right ☐ Left ☐ Both

4. ANATOMICAL LOSS, LIGHT PERCEPTION ONLY, EXTREMELY POOR VISION OR BLINDNESS

Does the veteran have anatomical loss, light perception only, extremely poor vision or blindness of either eye?

☐ Yes ☐ No *(If "Yes," complete Items 4A thru 4E)*

a. Does the veteran have anatomical loss of either eye? ☐ Yes ☐ No

If "Yes," indicate for which eye ☐ Right ☐ Left ☐ Both

If "Yes," is veteran able to wear an ocular prosthesis ☐ Yes ☐ No

If "No," provide reason ____________________

b. Is the veteran's vision limited to no more than light perception only in either eye? ☐ Yes ☐ No

If "Yes," indicate for which eye(s) the veteran's vision is limited to no more than light perception ☐ Right ☐ Left ☐ Both

c. Is the veteran able to recognize test letters at 1 foot or closer? ☐ Yes ☐ No

If "No," indicate with which eye(s) the veteran is unable to recognize test letters at 1 foot or closer ☐ Right ☐ Left ☐ Both

d. Is the veteran able to perceive objects, hand movements, or count fingers at 3 feet? ☐ Yes ☐ No

If "No," indicate with which eye(s) the veteran is unable to perceive objects, hand movements, or count fingers at 3 feet: ☐ Right ☐ Left ☐ Both

e. Does the veteran have visual acuity of 20/200 or less in the better eye with use of a correcting lens based upon visual acuity loss *(i.e. USA statutory blindness with bilateral visual acuity of 20/200 or less)?*

☐ Yes ☐ No

5. ASTIGMATISM

Does the veteran have a corneal irregularity that results in severe irregular astigmatism? ☐ Yes ☐ No

(If "Yes," complete Items 5A and 5B)

a. Does the veteran customarily wear contact lenses to correct for the above corneal irregularity? ☐ Yes ☐ No

If "Yes," does using contact lenses result in more visual improvement than using the standard spectacle correction? ☐ Yes ☐ No

b. Was the corrected visual acuity determined using contact lenses? ☐ Yes ☐ No

If "No," explain: ____________________

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SECTION III - PHYSICAL EXAMINATION *(Continued)*

6. DIPLOPIA

Does the veteran have diplopia *(double vision)*? ☐ Yes ☐ No

a. Provide etiology *(such as traumatic injury, thyroid eye disease, myasthenia gravis, etc.)*:

b. The areas of diplopia must be documented on a Goldmann perimeter chart that identifies the four major quadrants *(upward, downward, left lateral and right lateral)* and the central field *(20 degrees or less)*. Include the chart with this questionnaire.

Report the results from the Goldmann perimeter chart below.

Indicate the areas where diplopia is present *(the fields in which the veteran sees double using binocular vision)*

☐ Central 20 degrees	☐ 21 to 30 degrees	☐ 31 to 40 degrees	☐ Greater than 40 degrees
	☐ Down	☐ Down	☐ Down
	☐ Lateral	☐ Lateral	☐ Lateral
	☐ Up	☐ Up	☐ Up

c. Indicate frequency of the diplopia: ☐ Constant ☐ Occasional

If occasional, indicate frequency of diplopia and most recent occurrence: ______

d. Is the diplopia correctable with standard spectacle correction? ☐ Yes ☐ No *(If "No," complete Item 6E)*

e. Is the diplopia correctable with standard spectacle correction that includes a special prismatic correction? ☐ Yes ☐ No

7. TONOMETRY

a. If tonometry was performed, provide results:

Right eye pressure: ______ Left eye pressure: ______

b. Tonometry method used:

☐ Goldmann applanation

☐ Other *(Describe)*: ______

8. SLIT LAMP AND EXTERNAL EYE EXAM

a. External exam/lids/lashes:

Right: ☐ Normal ☐ Other *(Describe)*: ______

Left: ☐ Normal ☐ Other *(Describe)*: ______

b. Conjunctiva:

Right: ☐ Normal ☐ Other *(Describe)*: ______

Left: ☐ Normal ☐ Other *(Describe)*: ______

c. Cornea:

Right: ☐ Normal ☐ Other *(Describe)*: ______

Left: ☐ Normal ☐ Other *(Describe)*: ______

d. Anterior chamber:

Right: ☐ Normal ☐ Other *(Describe)*: ______

Left: ☐ Normal ☐ Other *(Describe)*: ______

e. Iris:

Right: ☐ Normal ☐ Other *(Describe)*: ______

Left: ☐ Normal ☐ Other *(Describe)*: ______

f. Lens:

Right: ☐ Normal ☐ Other *(Describe)*: ______

Left: ☐ Normal ☐ Other *(Describe)*: ______

9. INTERNAL EYE EXAM *(FUNDUS)*

Fundus:

☐ Normal bilaterally ☐ Abnormal *(If Abnormal, complete Items 9A thru 9E)*

a. Optic disc:

Right: ☐ Normal ☐ Other *(Describe)*: ______

Left: ☐ Normal ☐ Other *(Describe)*: ______

b. Macula:

Right: ☐ Normal ☐ Other *(Describe)*: ______

Left: ☐ Normal ☐ Other *(Describe)*: ______

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SECTION III - PHYSICAL EXAMINATION *(Continued)*

9. INTERNAL EYE EXAM *(Continued)*

c. Vessels

Right: ☐ Normal ☐ Other *(Describe)*: ______

Left: ☐ Normal ☐ Other *(Describe)*: ______

d. Vitreous

Right: ☐ Normal ☐ Other *(Describe)*: ______

Left: ☐ Normal ☐ Other *(Describe)*: ______

e. Periphery

Right: ☐ Normal ☐ Other *(Describe)*: ______

Left: ☐ Normal ☐ Other *(Describe)*: ______

10. VISUAL FIELDS

Does the veteran have a visual field defect *(or a condition that may result in a visual field defect)?*

☐ Yes ☐ No *(If "Yes," complete Items 10A thru 10E)*

NOTE: For VA purposes, examiners must perform visual field testing using either Goldmann kinetic perimetry or automated perimetry using Humphrey Model 750, Octopus Model 101, or later versions of these perimetric devices with simulated kinetic Goldmann testing capability. The results must be recorded on a standard Goldmann chart providing at least 16 meridians 22½-degrees apart for each eye and **included with this questionnaire**.
If additional testing is necessary to evaluate visual fields, it must be conducted using either a tangent screen or a 30-degree threshold visual field with the Goldmann III stimulus size. The examination report must then include the tracing of either the tangent screen or of the 30-degree threshold visual field with the Goldmann III stimulus size.

a. Was visual field testing performed? ☐ Yes ☐ No

Results ☐ Using Goldmann's equivalent III/4e target

☐ Using Goldmann's equivalent IV/4e target *(used for aphakic individuals not well adapted to contact lens correction or pseudophakic individuals not well adapted to intraocular lens implant)*

☐ Other *(Describe)*: ______

b. Does the veteran have loss of a visual field? ☐ Yes ☐ No

c. Does the veteran have loss of a visual field? ☐ Yes ☐ No *(If "Yes," check all that apply and indicate eye affected):*

☐ Homonymous hemianopsia ☐ Right ☐ Left ☐ Both

☐ Loss of temporal half of visual field ☐ Right ☐ Left ☐ Both

☐ Loss of nasal half of visual field ☐ Right ☐ Left ☐ Both

☐ Loss of inferior half of visual field ☐ Right ☐ Left ☐ Both

☐ Loss of superior half of visual field ☐ Right ☐ Left ☐ Both

☐ Other *(Specify:)* ______

d. Does the veteran have a scotoma? ☐ Yes ☐ No *(If "Yes," check all that apply and indicate eye affected):*

☐ Scotoma affecting at least 1/4 of the visual field ☐ Right ☐ Left ☐ Both

☐ Centrally located scotoma ☐ Right ☐ Left ☐ Both

e. Does the veteran have legal *(statutory)* blindness *(visual field diameter of 20 degrees or less in the better eye, even if the corrected visual acuity is 20/20)* based upon visual field loss?

☐ Yes ☐ No

SECTION IV - EYE CONDITIONS

1. CONDITIONS

Does the veteran have any of the following eye conditions? ☐ Yes ☐ No *(If "No," proceed to Section V) (If "Yes," check all that apply)*

☐ Anatomical loss of eyelids and/or brows *(If checked, complete Item 2 below)*

☐ Lacrimal gland and lid disorders *(other than ptosis or anatomic loss) (If checked, complete Item 3 below)*

☐ Ptosis, for either or both eyelids *(If checked, complete Item 4 below)*

☐ Conjunctivitis and other conjunctival conditions *(If checked, complete Item 5 below)*

☐ Corneal conditions *(If checked, complete Item 6 below)*

☐ Inflammatory eye conditions and/or injuries *(If checked, complete Item 8 below)*

☐ Glaucoma *(If checked, complete Item 9 below)*

☐ Cataracts and lens conditions *(If checked, complete Item 10 below)*

☐ Retinal conditions *(If checked, complete Item 11 below)*

☐ Neurologic eye conditions *(If checked, complete Item 12 below)*

☐ Tumors and Neoplasms *(If checked, complete Item 13 below)*

☐ Other eye condition(s) *(If checked, complete Item 14 below)*

For each checked answer, complete the appropriate item *(items 2 thru 14)*

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SECTION IV - EYE CONDITIONS *(Continued)*

2. ANATOMICAL LOSS OF EYELIDS, BROWS, LASHES

a. Indicate the condition and side affected *(Check all that apply)*

☐ Partial or complete loss of eyelid ☐ Right ☐ Left ☐ Both
☐ Complete loss of eyebrows ☐ Right ☐ Left ☐ Both
☐ Complete loss of eyelashes ☐ Right ☐ Left ☐ Both

b. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to eyelid loss?

☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment

If "No," explain: ____________________

c. If present, does eyelid loss cause scarring or disfigurement? ☐ Yes ☐ No *(If "Yes," complete Section V, Scarring and Disfigurement)*

3. LACRIMAL GLAND AND LIP CONDITIONS

a. Indicate the veteran's condition(s) and side affected *(Check all that apply)*:

☐ Ectropion Side affected: ☐ Right ☐ Left ☐ Both
☐ Entropion Side affected: ☐ Right ☐ Left ☐ Both
☐ Lagophthalmos Side affected: ☐ Right ☐ Left ☐ Both
☐ Disorders of the lacrimal apparatus *(epiphora, dacryocystitis, etc.)*

If checked, specify condition: ____________________

Side affected: ☐ Right ☐ Left ☐ Both

b. If present, does lacrimal or lid condition cause scarring or disfigurement? ☐ Yes ☐ No *(If "Yes," complete Section V, Scarring and Disfigurement)*

4. PTOSIS

a. If ptosis is present, indicate side affected: ☐ Right ☐ Left ☐ Both

b. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to ptosis?

☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment

If "No," explain: ____________________

c. Does the Ptosis loss cause disfigurement? ☐ Yes ☐ No *(If "Yes," complete Section V, Scarring and Disfigurement)*

5. CONJUNCTIVITIS AND OTHER CONJUCTIVAL CONDITIONS

a. Indicate type of conjunctivitis, activity, and side affected *(check all that apply)*:

☐ Trachomatous
☐ Active Eye affected: ☐ Right ☐ Left ☐ Both
☐ Inactive Eye affected: ☐ Right ☐ Left ☐ Both

☐ Nontrachomatous
☐ Active Eye affected: ☐ Right ☐ Left ☐ Both
☐ Inactive Eye affected: ☐ Right ☐ Left ☐ Both

b. Indicate the veteran's other conjunctival conditions, if any *(Check all that apply):*

☐ Pinguecula Eye affected: ☐ Right ☐ Left ☐ Both
☐ Symblepharon Eye affected: ☐ Right ☐ Left ☐ Both
☐ Other, describe: ____________________

Eye affected: ☐ Right ☐ Left ☐ Both

c. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the eye conditions checked above in this section?

☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment

If "No," explain: ____________________

d. Does any eye condition in this section cause scarring or disfigurement? ☐ Yes ☐ No *(If "Yes," complete Section V, Scarring and Disfigurement)*

6. CORNEAL CONDITIONS

a. Has the veteran had a corneal transplant? ☐ Yes ☐ No

If "Yes," indicate side of transplant: ☐ Right ☐ Left ☐ Both

Indicate residuals *(Check all that apply):*

☐ Pain Eye affected: ☐ Right ☐ Left ☐ Both
☐ Photophobia Eye affected: ☐ Right ☐ Left ☐ Both
☐ Glare sensitivity Eye affected: ☐ Right ☐ Left ☐ Both
☐ Other, *(Describe)*: ____________________

Eye affected: ☐ Right ☐ Left ☐ Both

b. Does the veteran have keratoconus? ☐ Yes ☐ No

If "Yes," indicate eye affected ☐ Right ☐ Left ☐ Both

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SECTION IV - EYE CONDITIONS *(Continued)*

6. CORNEAL CONDITIONS *(Continued)*

c. Does the veteran have pterygium? ☐ Yes ☐ No

If "Yes," indicate eye affected ☐ Right ☐ Left ☐ Both

d. Does the veteran have another corneal condition that may result in an irregular cornea? *(For example, pellucid marginal degeneration, irregular astigmatism from corneal scar, post-laser refractive surgery, acne rosacea keratopathy, etc.)*

☐ Yes ☐ No

If "Yes," specify corneal condition ____________________

Eye affected: ☐ Right ☐ Left ☐ Both

e. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to keratoconus or another corneal condition, if present?

☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment

If "Yes," specify corneal condition responsible for visual impairment ____________________

If "No," explain: ____________________

f. Does any eye condition identified in this section cause scarring or disfigurement? ☐ Yes ☐ No *(If "Yes," complete Section V, Scarring and Disfigurement)*

7. CATARACT AND OTHER LENS CONDITIONS

a. Indicate cataract condition:

☐ Preoperative *(cataract is present)* Eye affected: ☐ Right ☐ Left ☐ Both

☐ Postoperative *(cataract has been removed)* Eye affected: ☐ Right ☐ Left ☐ Both

Is there aphakia or dislocation of the crystalline lens? ☐ Yes ☐ No

If "Yes," indicate eye ☐ Right ☐ Left ☐ Both

b. Is there a replacement intraocular lens? ☐ Yes ☐ No

If "Yes," indicate eye ☐ Right ☐ Left ☐ Both

c. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the eye conditions checked above in this section?

☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment

If "Yes," specify corneal condition responsible for visual impairment ____________________

If "No," explain ____________________

8. INFLAMMATORY EYE CONDITIONS AND/OR INJURIES

a. Indicate the veteran's condition and eye affected:

☐ Choroidopathy *(including uveitis, iritis, cyclitis, and choroiditis)* ☐ Right ☐ Left ☐ Both

☐ Keratopathy ☐ Right ☐ Left ☐ Both

☐ Scleritis ☐ Right ☐ Left ☐ Both

☐ Intraocular hemorrhage ☐ Right ☐ Left ☐ Both

☐ Unhealed eye injury ☐ Right ☐ Left ☐ Both

☐ Other, *(Describe)*: ____________________

b. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any eye condition and/or injury checked above in this section?

☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment

If "Yes," specify inflammatory or traumatic condition responsible for visual impairment ____________________

If "No," explain ____________________

c. Does any eye condition identified in this section cause scarring or disfigurement? ☐ Yes ☐ No *(If "Yes," complete Section V, Scarring and Disfigurement)*

9. GLAUCOMA

a. Specify the type of glaucoma:

☐ Angle-closure Eye affected: ☐ Right ☐ Left ☐ Both

☐ Open-angle Eye affected: ☐ Right ☐ Left ☐ Both

☐ Other, specify type *(For example, neovascular, phakolytic, etc.)*: ____________________

Eye affected: ☐ Right ☐ Left ☐ Both

b. Does the glaucoma require continuous medication for treatment? ☐ Yes ☐ No

If "Yes," indicate side affected ☐ Right ☐ Left ☐ Both

List medication(s) used for treatment of glaucoma: ____________________

c. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to glaucoma?

☐ Yes ☐ No ☐ There is no decrease in visual acuity or other visual impairment

If "No," explain: ____________________

d. Does any eye glaucoma condition identified in this section cause scarring or disfigurement? ☐ Yes ☐ No *(If "Yes," complete Section V, Scarring and Disfigurement)*

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SECTION IV - EYE CONDITIONS *(Continued)*

10. OPTIC NEUROPATHY AND OTHER DISC CONDITIONS

a. Indicate the optic neuropathy and other disc conditions, and eye affected *(check all that apply)*:

- [ ] Drusen of optic disc — [ ] Right [ ] Left [ ] Both
- [ ] Ischemic optic neuropathy — [ ] Right [ ] Left [ ] Both
- [ ] Nutritional optic neuropathy — [ ] Right [ ] Left [ ] Both
- [ ] Optic atrophy — [ ] Right [ ] Left [ ] Both
- [ ] Other, *(Describe)*: — [ ] Right [ ] Left [ ] Both

b. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the eye conditions checked in Item 10A?

[ ] Yes [ ] No [ ] There is no decrease in visual acuity or other visual impairment

If "Yes," specify optic neuropathy or disc condition responsible for visual impairment ______

If "No," explain ______

11. RETINAL CONDITIONS

a. Indicate retinal condition and eye affected *(check all that apply)*:

- [ ] Retinopathy — [ ] Right [ ] Left [ ] Both
- [ ] Maculopathy — [ ] Right [ ] Left [ ] Both
- [ ] Detached retina — [ ] Right [ ] Left [ ] Both
- [ ] Retinal hemorrhage — [ ] Right [ ] Left [ ] Both
- [ ] Centrally located retinal scars, atrophy or irregularities in either eye that result in irregular, duplicated, enlarged or diminished image in either eye — [ ] Right [ ] Left [ ] Both

b. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the eye conditions checked in Item 11A?

[ ] Yes [ ] No [ ] There is no decrease in visual acuity or other visual impairment

If "Yes," specify retinal condition responsible for visual impairment ______

If "No," explain ______

12. NEUROLOGIC EYE CONDITIONS

a. Indicate the veteran's neurologic eye condition/disorder:

- [ ] Nystagmus
  If checked, is nystagmus etiology central? [ ] Yes [ ] No
- [ ] Paresis/paralysis of 3rd cranial nerve *(oculomotor)* — Eye affected: [ ] Right [ ] Left [ ] Both
- [ ] Paresis/paralysis of 4th cranial nerve *(trochlear)* — Eye affected: [ ] Right [ ] Left [ ] Both
- [ ] Paresis/paralysis of 6th cranial nerve *(abducens)* — Eye affected: [ ] Right [ ] Left [ ] Both
- [ ] Paresis/paralysis of 7th cranial nerve *(facial, Bell's palsy)* — Eye affected: [ ] Right [ ] Left [ ] Both
- [ ] Eye condition due to cerebrovascular accident *(CVA)* — Eye affected: [ ] Right [ ] Left [ ] Both
  If checked, specify eye condition attributable to CVA: ______
- [ ] Eye condition due to demyelinating disease — Eye affected: [ ] Right [ ] Left [ ] Both
  If checked, specify eye condition attributable to demyelinating disease: ______
- [ ] Optic neuritis — Eye affected: [ ] Right [ ] Left [ ] Both
- [ ] Eye condition due to intracranial mass/tumor — Eye affected: [ ] Right [ ] Left [ ] Both
  If checked, specify eye condition attributable to intracranial mass/tumor: ______
- [ ] Eye condition due to traumatic brain injury *(TBI)* — Eye affected: [ ] Right [ ] Left [ ] Both
  If checked, specify eye condition attributable to TBI: ______
- [ ] Other If checked, specify neurologic eye condition/disorder and name the underlying neurologic condition *(for example. Alzheimer's disease, Jakob-Creutzfeldt disease, etc.)*
  ______
  Eye affected: [ ] Right [ ] Left [ ] Both

b. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the neurologic eye conditions checked above in this section?

[ ] Yes [ ] No [ ] There is no decrease in visual acuity or other visual impairment

If "Yes," specify condition responsible for visual impairment: ______

If "No," explain: ______

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SECTION IV - EYE CONDITIONS *(Continued)*

13. TUMORS AND NEOPLASMS

Does the veteran have a benign or malignant neoplasm or metastases related to any of the diagnosis listed in Section 1, Diagnosis? ☐ Yes ☐ No
(If "Yes," complete Items 13A thru 13E):

a. Is the neoplasm: ☐ Benign ☐ Malignant

b. 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: __________

c. 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 in Item 13B?

☐ Yes ☐ No

If "Yes," list residual conditions and complication *(Brief summary)*:

d. If there are additional benign or malignant neoplasms or metastases related to any of the diagnosis in Section I, Diagnosis, describe using the format in Item 13B:

e. Do any benign or malignant neoplasms or metastases identified in this section cause scarring or disfigurement? ☐ Yes ☐ No
(If "Yes," complete Section V, Scarring and Disfigurement)

14. OTHER EYE CONDITIONS, PERTINENT PHYSICAL FINDINGS, COMPLICATION, CONDITIONS, SIGNS AND/OR SYMPTOMS

a. Does the veteran have any other eye conditions, pertinent physical findings, complications, signs, and/or related to the condition at hand? ☐ Yes ☐ No

If "Yes," describe:

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER [ ] – [ ] – [ ]

SECTION V - SCARRING AND DISFIGUREMENT

5. DOES THE VETERAN HAVE SCARRING OR DISFIGUREMENT ATTRIBUTABLE TO ANY EYE CONDITION?

☐ Yes ☐ No

IF YES, INDICATE SCAR ATTRIBUTES *(check all that apply):*

☐ Scar at least one-quarter inch *(0.6cm)* wide at widest part
☐ Surface contour of scar elevated or depressed on palpation *(or inspection in the case of sclera)*
☐ Scar adherent to underlying tissue *(including eyelids adherent to scleral tissue)*
☐ Visible or palpable tissue loss
☐ Gross distortion or asymmetry of one feature or paired set of features *(eyes)*

NOTE: If possible, include color photographs with any report of scarring or disfigurement.

SECTION VI - INCAPACITATING EPISODES

NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician or other healthcare provider *(For example, temporary bed rest required for a retinal condition)*.

6A. DURING THE PAST 12 MONTHS, HAS THE VETERAN HAD ANY INCAPACITATING EPISODES ATTRIBUTABLE TO ANY EYE CONDITION?

☐ Yes ☐ No

If "Yes," specify the eye condition(s) causing incapacitating episodes: ____________________

6B. DESCRIBE HOW THE EYE CONDITION(S) CAUSED INCAPACITATING EPISODES:

6C. PROVIDE THE TOTAL DURATION FOR THE INCAPACITATING EPISODES FOR ALL INCAPACITATING CONDITIONS OVER THE PAST 12 MONTHS:

☐ Less than 1 week
☐ At least 1 week but less than 2 weeks
☐ At least 2 weeks but less than 4 weeks
☐ At least 4 weeks but less than 6 weeks
☐ At least six weeks

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER [ ] – [ ] – [ ]

SECTION VII - FUNCTIONAL IMPACT

7A. DOES THE VETERAN'S EYE CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ Yes ☐ No

If "Yes," describe the impact of each of the veteran's eye condition(s), providing one or more examples:

SECTION VIII - REMARKS

8. REMARKS *(If any)*

SECTION IX - OPTOMETRIST/PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9A. OPTOMETRIST/PHYSICIAN'S SIGNATURE *(Sign in ink)*	9B. OPTOMETRIST/PHYSICIAN'S PRINTED NAME	9C. DATE SIGNED

9D. OPTOMETRIST/PHYSICIAN'S PHONE/FAX NUMBER	9E. OPTOMETRIST/PHYSICIAN'S NATIONAL PROVIDER IDENTIFIER (NPI)	9F. OPTOMETRIST/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** 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 45 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.