Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
KNEE AND LOWER LEG 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 - The veteran or service member 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 claim. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA21-2507, C&P EXAMINATION REQUEST?

☐ YES ☐ NO

How was the examination completed? (check all that apply)

☐ In-person examination
☐ Records reviewed
☐ Examination via approved video telehealth
☐ Other, please specify in comments box:

Comments:

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
☐ VA claims file (hard copy paper C-file
☐ VA e-folder (VBMS or Virtual VA
☐ CPRS
☐ Other (please identify other evidence reviewed):
☐ No records were reviewed

EVIDENCE COMMENTS:

SECTION I - DIAGNOSIS

NOTE: These are condition(s) for which an evaluation has been requested on an 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 DBQ:

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, explain your findings and reasons in comments section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date determined through record review or reported history.

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 listed above. *(Explain your findings and reasons in comments section.)*

	Side affected:	ICD Code:	Date of diagnosis:
☐ Knee strain	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Knee tendonitis/tendonosis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Knee meniscal tear	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Knee anterior cruciate ligament tear	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Knee posterior cruciate ligament tear	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Patellar or quadriceps tendon rupture	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Knee joint osteoarthritis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Knee joint ankylosis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Knee fracture *(including patellar fracture)*	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Stress fracture of tibia	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Tibia and/or Fibula fracture	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Recurrent patellar dislocation	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Recurrent subluxation	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Knee instability	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Patellar dislocation	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Knee cartilage restoration surgery	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Shin splints *(including tibia and/or fibula stress fracture and/or exertional compartment syndrome)*	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Patellofemoral pain syndrome	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____

☐ Arthritic conditions	Side affected:	ICD Code:	Date of diagnosis:
☐ Arthritis, degenerative	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, gonorrheal	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, pneumococcic	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, streptococcic	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, syphilitic	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, rheumatoid	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, traumatic	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, typhoid	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Arthritis, other types *(specify)* _____	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____

☐ Inflammatory conditions	Side affected:	ICD Code:	Date of diagnosis:
☐ Osteoporosis, with joint manifestations	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Osteomalacia	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Bones, new growths of, benign	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Osteitis deformans	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Gout	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Hydrarthrosis, intermittent	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Bursitis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Synovitis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Myositis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Periostitis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Myositis ossificans	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Tenosynovitis	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____
☐ Inflammatory, other types *(specify)* _____	☐ Right ☐ Left ☐ Both	_____	Right: _____ Left: _____

SECTION I - DIAGNOSIS *(Continued)*

1B. SELECT DIAGNOSES ASSOCIATED WITH THE CLAIMED CONDITION(S) *(Check all that apply) (Continued)*

☐ Other *(specify)*

Other diagnosis #1: _____

Side affected: ☐ Right ☐ Left ☐ Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

Other diagnosis #2: _____

Side affected: ☐ Right ☐ Left ☐ Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

Other diagnosis #3: _____

Side affected: ☐ Right ☐ Left ☐ Both ICD Code: _____ Date of diagnosis: Right: _____ Left: _____

If there are additional diagnoses that pertain to shoulder conditions, list using above format:

1C. COMMENTS *(if any):*

1D. WAS AN OPINION REQUESTED ABOUT THIS CONDITION *(internal VA only)*?

☐ YES ☐ NO ☐ N/A

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S KNEE AND/OR LOWER LEG CONDITION *(brief summary):*

2B. DOES THE VETERAN REPORT FLARE-UPS OF THE KNEE AND/OR LOWER LEG?

☐ YES ☐ NO

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

2C. DOES THE VETERAN REPORT HAVING ANY FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT OF THE JOINT OR EXTREMITY BEING EVALUATED ON THIS DBQ, INCLUDING BUT NOT LIMITED TO REPEATED USE OVER TIME?

☐ YES ☐ NO

IF YES, DOCUMENT THE VETERAN'S DESCRIPTION OF FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT IN HIS OR HER OWN WORDS:

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

There are several separate parameters requested for describing function of a joint. The question of "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 that repetitive use over time or during a flare up, however, this is not always feasible.

Information regarding joint function is broken up into two subsets. First is based on repetitive use and the second functional loss associated with flare ups. The repetitive use section initially asks for objective findings after three or more repetitions of ranges of motion testing. The second portion 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, taking into account not only on the objective findings noted on the examination but also the subjective history provided by the claimant as well as review of available medical evidence.

Optimally, description of any additional loss of function should be provided as what the degrees range of motion would be opined to look like in these given scenarios. However, when this is not feasible, a 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.

3A. INITIAL ROM MEASUREMENTS

RIGHT KNEE

☐ All Normal ☐ Unable to test
☐ Abnormal or outside of normal range ☐ Not indicated

If 'Unable to test' or "Not indicated", please explain:

Flexion (0-140 degrees): _____ to _____ degrees Extension (140-0 degrees): _____ to _____ degrees

If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than a knee/lower leg condition, such as age, body habitus, neurologic disease), please describe:

If abnormal, does the range of motion itself contribute to a functional loss?
☐ Yes ☐ No
If yes, please explain:

Description of Pain *(select the best response)*:
☐ No pain noted on exam
☐ Pain noted on exam on rest / non-movement
☐ Pain noted on exam but does not result in / cause functional loss
☐ Pain noted on examination and causes functional loss

If noted on examination, which ROM exhibited pain *(select all that apply)*:
☐ Flexion ☐ Extension

Is there evidence of pain with weight bearing?
☐ Yes ☐ No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? ☐ Yes ☐ No
If yes, please explain. Include location, severity, and relationship to condition(s).

Is there objective evidence of crepitus?
☐ Yes ☐ No

LEFT KNEE

☐ All Normal ☐ Unable to test
☐ Abnormal or outside of normal range ☐ Not indicated

If 'Unable to test' or "Not indicated", please explain:

Flexion (0-140 degrees): _____ to _____ degrees Extension (140-0 degrees): _____ to _____ degrees

If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than a knee/lower leg condition, such as age, body habitus, neurologic disease), please describe:

If abnormal, does the range of motion itself contribute to a functional loss?
☐ Yes ☐ No
If yes, please explain:

Description of Pain *(select the best response)*:
☐ No pain noted on exam
☐ Pain noted on exam on rest / non-movement
☐ Pain noted on exam but does not result in / cause functional loss
☐ Pain noted on examination and causes functional loss

If noted on examination, which ROM exhibited pain *(select all that apply)*:
☐ Flexion ☐ Extension

Is there evidence of pain with weight bearing?
☐ Yes ☐ No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? ☐ Yes ☐ No
If yes, please explain. Include location, severity, and relationship to condition(s).

Is there objective evidence of crepitus?
☐ Yes ☐ No

3B. OBSERVED REPETITIVE USE

	Is the veteran able to perform repetitive-use testing with at least three repetitions?	Is there additional loss of function or range of motion after three repetitions?
RIGHT KNEE	☐ Yes ☐ No If no, provide reason:	☐ Yes ☐ No Select all factors that cause this functional loss: ☐ N/A ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination ROM after 3 repetitions: Flexion (0-140) _____ to _____ Extension (140-0) _____ to _____
LEFT KNEE	Is the veteran able to perform repetitive-use testing with at least three repetitions?	Is there additional loss of function or range of motion after three repetitions?
	☐ Yes ☐ No If no, provide reason:	☐ Yes ☐ No Select all factors that cause this functional loss: ☐ N/A ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination ROM after 3 repetitions: Flexion (0-140) _____ to _____ Extension (140-0) _____ to _____

3C. REPEATED USE OVER TIME

	Is the Veteran being examined immediately after repetitive use over time?	If the examination is ***not*** being conducted immediately after repetitive use over time:	If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:
RIGHT KNEE	☐ Yes ☐ No	☐ The examination is medically consistent with the Veteran's statements describing functional loss with repetitive use over time. ☐ The examination is medically inconsistent with the Veteran's statements describing functional loss with repetitive use over time. ☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss with repetitive use over time.	
	Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time? ☐ Yes ☐ No ☐ Unable to say without mere speculation	If unable to say without mere speculation, please explain:	
	Select all factors that cause this functional loss: ☐ N/A ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination		
	Are you able to describe in terms of Range of Motion? ☐ Yes ☐ No	If no, please describe:	
	Flexion (0-140 degrees): _____ to _____ degrees Extension (140-0 degrees): _____ to _____ degrees		
LEFT KNEE	Is the Veteran being examined immediately after repetitive use over time?	If the examination is ***not*** being conducted immediately after repetitive use over time:	If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:
	☐ Yes ☐ No	☐ The examination is medically consistent with the Veteran's statements describing functional loss with repetitive use over time. ☐ The examination is not medically consistent with the Veteran's statements describing functional loss with repetitive use over time. ☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss with repetitive use over time.	
	Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time? ☐ Yes ☐ No ☐ Unable to say without mere speculation	If unable to say without mere speculation, please explain:	
	Select all factors that cause this functional loss: ☐ N/A ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination		
	Are you able to describe in terms of Range of Motion? ☐ Yes ☐ No	If no, please describe:	
	Flexion (0-140 degrees): _____ to _____ degrees Extension (140-0 degrees): _____ to _____ degrees		

3D. FLARE UPS

RIGHT KNEE

Is the examination being conducted during a flare up?	If the examination is ***not*** being conducted during a flare up:	If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:
☐ Yes ☐ No	☐ The examination is medically consistent with the Veteran's statements describing functional loss during flare up. ☐ The examination is medically inconsistent with the Veteran's statements describing functional loss during flare up. ☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss during flare up.	

Does pain, weakness, fatigability or incoordination significantly limit functional ability with flare ups?

☐ Yes ☐ No ☐ Unable to say without mere speculation

If unable to say without mere speculation, please explain:

Select all factors that cause this functional loss: ☐ N/A ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination

Are you able to describe in terms of Range of Motion? ☐ Yes ☐ No

If no, please describe:

Flexion (0-140 degrees): _____ to _____ degrees

Extension (140-0 degrees): _____ to _____ degrees

LEFT KNEE

Is the examination being conducted during a flare up?	If the examination is ***not*** being conducted during a flare up:	If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:
☐ Yes ☐ No	☐ The examination is medically consistent with the Veteran's statements describing functional loss during flare up. ☐ The examination is medically inconsistent with the Veteran's statements describing functional loss during flare up. ☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss during flare up.	

Does pain, weakness, fatigability or incoordination significantly limit functional ability with flare ups?

☐ Yes ☐ No ☐ Unable to say without mere speculation

If unable to say without mere speculation, please explain:

Select all factors that cause this functional loss: ☐ N/A ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination

Are you able to describe in terms of Range of Motion? ☐ Yes ☐ No

If no, please describe:

Flexion (0-140 degrees): _____ to _____ degrees

Extension (140-0 degrees): _____ to _____ degrees

3E. ADDITIONAL FACTORS CONTRIBUTING TO DISABIITY

RIGHT KNEE

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

☐ None

☐ Less movement than normal due to ankylosis, adhesions, etc.
☐ More movement than normal due to flail joints, fracture nonunions, etc.
☐ Weakened movement due to muscle injury or peripheral nerves injury, etc.
☐ Swelling
☐ Deformity
☐ Atrophy of disuse ☐ Other, describe:
☐ Instability of station
☐ Disturbance of locomotion
☐ Interference with sitting
☐ Interference with standing

Please describe additional contributing factors of disability:

3E. ADDITIONAL FACTORS CONTRIBUTING TO DISABIITY *(Continued)*

LEFT KNEE

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

- ☐ None
- ☐ Less movement than normal due to ankylosis, adhesions, etc.
- ☐ More movement than normal due to flail joints, fracture nonunions, etc.
- ☐ Weakened movement due to muscle injury or peripheral nerves injury, etc.
- ☐ Swelling
- ☐ Deformity
- ☐ Atrophy of disuse
- ☐ Other, describe:
- ☐ Instability of station
- ☐ Disturbance of locomotion
- ☐ Interference with sitting
- ☐ Interference with standing

Please describe additional contributing factors of disability:

SECTION IV - MUSCLE STRENGTH TESTING

4A. MUSCLE STRENGTH - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance
5/5 Normal strength

Knee	Flexion/ Extension	Rate Strength	Is there a reduction in muscle strength?	If yes, is the reduction entirely due to the claimed condition in the Diagnosis section?	If no (the reduction is not entirely due to the claimed condition), provide rationale:
RIGHT KNEE	Flexion	/5	☐ Yes ☐ No	☐ Yes ☐ No	
	Extension	/5			
LEFT KNEE	Flexion	/5	☐ Yes ☐ No	☐ Yes ☐ No	
	Extension	/5			

4B. DOES THE VETERAN HAVE MUSCLE ATROPHY?

☐ YES ☐ NO

IF YES, IS THE MUSCLE ATROPHY DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO IF NO, PROVIDE RATIONALE:

FOR ANY MUSCLE ATROPHY DUE TO A DIAGNOSES LISTED IN SECTION 1, INDICATE SIDE AND SPECIFIC LOCATION OF ATROPHY, PROVIDING MEASUREMENTS IN CENTIMETERS OF NORMAL SIDE AND CORRESPONDING ATROPHIED SIDE, MEASURED AT MAXIMUM MUSCLE BULK.

LOCATION OF MUSCLE ATROPHY:

☐ RIGHT LOWER EXTREMITY *(specify location of measurement such as "10cm above or below elbow")*:

_____

CIRCUMFERENCE OF MORE NORMAL SIDE: _____ cm CIRCUMFERENCE OF ATROPHIED SIDE: _____ cm

☐ LEFT LOWER EXTREMITY *(specify location of measurement such as "10cm above or below elbow")*:

_____

CIRCUMFERENCE OF MORE NORMAL SIDE: _____ cm CIRCUMFERENCE OF ATROPHIED SIDE: _____ cm

4C. COMMENTS, IF ANY:

SECTION V - ANKYLOSIS

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

COMPLETE THIS SECTION IF THE VETERAN HAS ANKYLOSIS OF THE KNEE AND/OR LOWER LEG.

5A. INDICATE SEVERITY OF ANKYLOSIS AND SIDE AFFECTED *(check all that apply)*:

RIGHT SIDE:	LEFT SIDE:
☐ No ankylosis	☐ No ankylosis
☐ Favorable angle in full extension or in slight flexion between 0 and 10 degrees	☐ Favorable angle in full extension or in slight flexion between 0 and 10 degrees
☐ In flexion between 10 and 20 degrees	☐ In flexion between 10 and 20 degrees
☐ In flexion between 20 and 45 degrees	☐ In flexion between 20 and 45 degrees
☐ Extremely unfavorable, in flexion at an angle of 45 degrees or more	☐ Extremely unfavorable, in flexion at an angle of 45 degrees or more

5B. INDICATE ANGLE OF ANKYLOSIS IN DEGREES:

RIGHT SIDE:	LEFT SIDE:
☐ N/A, no ankylosis of knee joint	☐ N/A, no ankylosis of knee joint
_____ degrees	_____ degrees

5C. COMMENTS, IF ANY:

SECTION VI - JOINT STABILITY TESTS

NOTE: Subluxation and lateral instability refers only to the knee joint itself (tibio-femoral) and not to the patello-femoral portion of the joint.

6A. IS THERE A HISTORY OF RECURRENT SUBLUXATION?

Right: ☐ None ☐ Slight ☐ Moderate ☐ Severe

Left: ☐ None ☐ Slight ☐ Moderate ☐ Severe

6B. IS THERE A HISTORY OF LATERAL INSTABILITY?

Right: ☐ None ☐ Slight ☐ Moderate ☐ Severe

Left: ☐ None ☐ Slight ☐ Moderate ☐ Severe

6C. IS THERE A HISTORY OF RECURRENT EFFUSION?

☐ YES ☐ NO IF YES, DESCRIBE:

6D. PERFORMANCE OF JOINT STABILITY TESTING

	Was joint stability testing performed?	If joint stability testing was performed is there joint instability?	If yes *(joint stability testing was performed)*, complete the section below:	
RIGHT KNEE	☐ Yes ☐ No ☐ Not Indicated ☐ Indicated, but not able to perform If joint stability is indicated, but unable to test, provide reason:	☐ Yes ☐ No	Anterior instability *(Lachman test)*	☐ Normal ☐ 1+*(0-5 millimeters)* ☐ 2+*(5-10 millimeters)* ☐ 3+*(10-15 millimeters)*
			Posterior instability *(Posterior drawer test)*	☐ Normal ☐ 1+*(0-5 millimeters)* ☐ 2+*(5-10 millimeters)* ☐ 3+*(10-15 millimeters)*
			Medial instability *(Apply valgus pressure to knee in extension and with 30 degrees of flexion):*	☐ Normal ☐ 1+*(0-5 millimeters)* ☐ 2+*(5-10 millimeters)* ☐ 3+*(10-15 millimeters)*
			Lateral instability *(Apply valgus pressure to knee in extension and with 30 degrees of flexion):*	☐ Normal ☐ 1+*(0-5 millimeters)* ☐ 2+*(5-10 millimeters)* ☐ 3+*(10-15 millimeters)*
LEFT KNEE	☐ Yes ☐ No ☐ Not Indicated ☐ Indicated, but not able to perform If joint stability is indicated, but unable to test, provide reason:	☐ Yes ☐ No	Anterior instability *(Lachman test)*	☐ Normal ☐ 1+*(0-5 millimeters)* ☐ 2+*(5-10 millimeters)* ☐ 3+*(10-15 millimeters)*
			Posterior instability *(Posterior drawer test)*	☐ Normal ☐ 1+*(0-5 millimeters)* ☐ 2+*(5-10 millimeters)* ☐ 3+*(10-15 millimeters)*
			Medial instability *(Apply valgus pressure to knee in extension and with 30 degrees of flexion):*	☐ Normal ☐ 1+*(0-5 millimeters)* ☐ 2+*(5-10 millimeters)* ☐ 3+*(10-15 millimeters)*
			Lateral instability *(Apply valgus pressure to knee in extension and with 30 degrees of flexion):*	☐ Normal ☐ 1+*(0-5 millimeters)* ☐ 2+*(5-10 millimeters)* ☐ 3+*(10-15 millimeters)*

SECTION VI - JOINT STABILITY TESTS *(Continued)*

6E. COMMENTS, IF ANY:

SECTION VII - ADDITIONAL COMMENTS

7A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER HAD RECURRENT PATELLAR DISLOCATION, "SHIN SPLINTS" *(medial tibial stress syndrome)*, STRESS FRACTURES, CHRONIC EXERTIONAL COMPARTMENT SYNDROME OR ANY OTHER TIBIAL OR FIBULAR IMPAIRMENT?

☐ YES ☐ NO

IF YES, INDICATE CONDITION AND COMPLETE THE APPROPRIATE SECTIONS BELOW:

☐ RECURRENT PATELLAR DISLOCATION

IF CHECKED, INDICATE SEVERITY AND SIDE AFFECTED:

Right: ☐ None ☐ Slight ☐ Moderate ☐ Severe

Left: ☐ None ☐ Slight ☐ Moderate ☐ Severe

☐ "SHIN SPLINTS" *(medial tibial stress syndrome)*

INDICATE SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

Does this condition affect ROM of knee? ☐ Yes ☐ No *(If yes, complete ROM section of knee on this DBQ.)*

Does this condition affect ROM of ankle? ☐ Yes ☐ No *(If yes, complete VA form 21-0960M-2 ANKLE CONDITIONS to document ROM of ankle.)*

Describe current symptoms: _____

☐ STRESS FRACTURE OF THE LOWER LEG

INDICATE SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

Does this condition affect ROM of ankle? ☐ Yes ☐ No *(If yes, complete VA form 21-0960M-2 ANKLE CONDITIONS to document ROM of ankle.)*

Describe current symptoms: _____

☐ CHRONIC EXERTIONAL COMPARTMENT SYNDROME *(an exercise-induced neuromuscular condition that can cause pain and swelling, especially after repetitive movements such as marching)*

INDICATE SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

Does this condition affect ROM of ankle? ☐ Yes ☐ No *(If yes, complete VA form 21-0960M-2 ANKLE CONDITIONS to document ROM of ankle.)*

Describe current symptoms: _____

☐ ACQUIRED AND/OR TRAUMATIC GENU RECURVATUM WITH OBJECTIVELY DEMONSTRATED WEAKNESS AND INSECURITY IN WEIGHT-BEARING.

INDICATE SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

☐ LEG LENGTH DISCREPANCY *(shortening of any bones of the lower extremity)*

(If checked, provide length of each lower extremity in inches (to the nearest 1/4 inch) or centimeters measuring from the anterior superior iliac spine to the internal malleolus of the tibia.)

Measurements: Right leg: _____ ☐cm Left leg: _____ ☐cm

For any leg length discrepancy, please describe the relationship to the conditions listed in the Diagnosis section above:

7B. COMMENTS, IF ANY:

SECTION VIII - MENISCAL CONDITIONS

8A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER HAD A MENISCUS *(semilunar cartilage)* CONDITION?

☐ YES ☐ NO

(If "Yes," indicate severity and frequency of symptoms, and side affected):

RIGHT SIDE:	LEFT SIDE:
☐ No current symptoms	☐ No current symptoms
☐ Meniscal dislocation	☐ Meniscal dislocation
☐ Meniscal tear	☐ Meniscal tear
☐ Frequent episodes of joint "locking"	☐ Frequent episodes of joint "locking"
☐ Frequent episodes of joint pain	☐ Frequent episodes of joint pain
☐ Frequent episodes of joint effusion	☐ Frequent episodes of joint effusion
☐ Other	☐ Other

8B. FOR ALL CHECKED BOXES ABOVE, DESCRIBE:

SECTION IX - SURGICAL PROCEDURES

9. INDICATE ANY SURGICAL PROCEDURES THAT THE VETERAN HAS HAD PERFORMED AND PROVIDE THE ADDITIONAL INFORMATION AS REQUESTED *(check all that apply)*:

RIGHT SIDE:

☐ TOTAL KNEE JOINT REPLACEMENT

DATE OF SURGERY: _____

RESIDUALS:

☐ None
☐ Intermediate degrees of residual weakness, pain or limitation of motion
☐ Chronic residuals consisting of severe painful motion or weakness
☐ Other, describe:

☐ MENISCECTOMY, ARTHROSCOPIC OR OTHER KNEE SURGERY NOT DESCRIBED ABOVE:

TYPE OF SURGERY: _____

DATE OF SURGERY: _____

☐ RESIDUAL SIGNS OF SYMPTOMS DUE TO MENISCECTOMY, ARTHROSCOPIC OR OTHER KNEE SURGERY NOT DESCRIBED ABOVE:

DESCRIBE RESIDUALS:

LEFT SIDE:

☐ TOTAL KNEE JOINT REPLACEMENT

DATE OF SURGERY: _____

RESIDUALS:

☐ None
☐ Intermediate degrees of residual weakness, pain or limitation of motion
☐ Chronic residuals consisting of severe painful motion or weakness
☐ Other, describe:

☐ MENISCECTOMY, ARTHROSCOPIC OR OTHER KNEE SURGERY NOT DESCRIBED ABOVE:

TYPE OF SURGERY: _____

DATE OF SURGERY: _____

☐ RESIDUAL SIGNS OF SYMPTOMS DUE TO MENISCECTOMY, ARTHROSCOPIC OR OTHER KNEE SURGERY NOT DESCRIBED ABOVE:

DESCRIBE RESIDUALS:

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

10A. 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*):

10B. 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?

☐ 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: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

10C. COMMENTS, IF ANY:

SECTION XI - ASSISTIVE DEVICES

11A. 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 ASSISTIVE DEVICES USED *(check all that apply and indicate frequency)*:

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Brace	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutches	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

11B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION XII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

12. DUE TO THE VETERAN'S KNEE OR LOWER LEG CONDITION(S), IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTIONS REMAIN OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? *(Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)*

☐ YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROTHESIS WOULD EQUALLY SERVE THE VETERAN.

☐ NO

IF YES, INDICATE EXTREMITIES FOR WHICH THIS APPLIES: ☐ RIGHT LOWER ☐ LEFT LOWER

FOR EACH CHECKED EXTREMITY, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, DESCRIBE LOSS OF EFFECTIVE FUNCTION AND PROVIDE SPECIFIC EXAMPLES *(brief summary)*:

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 prothesis. 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.

SECTION XIII - DIAGNOSTIC TESTING

NOTE: Testing listed below is not indicated for every condition. The diagnosis of degenerative arthritis (osteoarthritis) or 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.

13A. HAVE IMAGING STUDIES OF THE KNEE BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, IS DEGENERATIVE OR TRAUMATIC ARTHRITIS DOCUMENTED?

☐ YES ☐ NO IF YES, INDICATE KNEE: ☐ RIGHT ☐ LEFT ☐ BOTH

13B. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS OR RESULTS?

☐ YES ☐ NO IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS *(brief summary)*:

13C. IF ANY TEST RESULTS ARE OTHER THAN NORMAL, INDICATE RELATIONSHIP OF ABNORMAL FINDINGS TO DIAGNOSED CONDITIONS:

SECTION XIV - 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.

14. REGARDLESS OF THE VETERAN'S CURRENT EMPLOYMENT STATUS, DO THE CONDITION(S) LISTED IN THE DIAGNOSIS SECTION IMPACT HIS OR 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 XV - REMARKS

15. REMARKS, IF ANY:

SECTION XVI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

16A. PHYSICIAN'S SIGNATURE	16B. PHYSICIAN'S PRINTED NAME	16C. DATE SIGNED

16D. PHYSICIAN'S PHONE & FAX NUMBER	16E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	16F. PHYSICIAN'S ADDRESS