OMB Approved No. 2900-0776
Respondent Burden: 30 minutes

Department of Veterans Affairs

SHOULDER AND ARM 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.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER HAD A SHOULDER AND/OR ARM CONDITION?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO SHOULDER AND/OR ARM CONDITIONS

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS:	SIDE AFFECTED: ☐ RIGHT ☐ LEFT ☐ BOTH
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS:	SIDE AFFECTED: ☐ RIGHT ☐ LEFT ☐ BOTH
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS:	SIDE AFFECTED: ☐ RIGHT ☐ LEFT ☐ BOTH

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO SHOULDER AND/OR ARM CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S SHOULDER AND/OR ARM CONDITION *(brief summary)*

2B. DOMINANT HAND:

☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

SECTION III - FLARE-UPS

3. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE SHOULDER AND/OR ARM?

☐ YES ☐ NO

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

SECTION IV - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS

4. MEASURE ROM WITH A GONIOMETER, ROUNDING EACH MEASUREMENT TO THE NEAREST 5 DEGREES. DURING THE MEASUREMENTS, DOCUMENT THE POINT AT WHICH PAINFUL MOTION BEGINS, EVIDENCED BY VISIBLE BEHAVIOR SUCH AS FACIAL EXPRESSION, WINCING, ETC. REPORT INITIAL MEASUREMENTS BELOW.

FOLLOWING THE INITIAL ASSESSMENT OF ROM, PERFORM REPETITIVE USE TESTING. FOR VA PURPOSES, REPETITIVE USE TESTING MUST BE INCLUDED IN ALL JOINT EXAMS. THE VA HAS DETERMINED THAT 3 REPETITIONS OF ROM *(at a minimum)* CAN SERVE AS A REPRESENTATIVE TEST OF THE EFFECT OF REPETITIVE USE. AFTER THE INITIAL MEASUREMENT, REASSESS ROM AFTER 3 REPETITIONS. REPORT POST-TEST MEASUREMENTS IN SECTION 5.

A. RIGHT SHOULDER FLEXION

Select where flexion ends *(normal endpoint is 180 degrees):*

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65
☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100 ☐ 105 ☐ 110 ☐ 115 ☐ 120 ☐ 125 ☐ 130 ☐ 135
☐ 140 ☐ 145 ☐ 150 ☐ 155 ☐ 160 ☐ 165 ☐ 170 ☐ 175 ☐ 180

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65
☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100 ☐ 105 ☐ 110 ☐ 115 ☐ 120 ☐ 125 ☐ 130 ☐ 135
☐ 140 ☐ 145 ☐ 150 ☐ 155 ☐ 160 ☐ 165 ☐ 170 ☐ 175 ☐ 180

SECTION IV - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS *(Continued)*

B. RIGHT SHOULDER ABDUCTION

Select where abduction ends *(normal endpoint is 180 degrees):*

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65
☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100 ☐ 105 ☐ 110 ☐ 115 ☐ 120 ☐ 125 ☐ 130 ☐ 135
☐ 140 ☐ 145 ☐ 150 ☐ 155 ☐ 160 ☐ 165 ☐ 170 ☐ 175 ☐ 180

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65
☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100 ☐ 105 ☐ 110 ☐ 115 ☐ 120 ☐ 125 ☐ 130 ☐ 135
☐ 140 ☐ 145 ☐ 150 ☐ 155 ☐ 160 ☐ 165 ☐ 170 ☐ 175 ☐ 180

C LEFT SHOULDER FLEXION

Select where flexion ends *(normal endpoint is 180 degrees):*

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65
☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100 ☐ 105 ☐ 110 ☐ 115 ☐ 120 ☐ 125 ☐ 130 ☐ 135
☐ 140 ☐ 145 ☐ 150 ☐ 155 ☐ 160 ☐ 165 ☐ 170 ☐ 175 ☐ 180

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65
☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100 ☐ 105 ☐ 110 ☐ 115 ☐ 120 ☐ 125 ☐ 130 ☐ 135
☐ 140 ☐ 145 ☐ 150 ☐ 155 ☐ 160 ☐ 165 ☐ 170 ☐ 175 ☐ 180

D. LEFT SHOULDER ABDUCTION

Select where abduction ends *(normal endpoint is 180 degrees):*

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65
☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100 ☐ 105 ☐ 110 ☐ 115 ☐ 120 ☐ 125 ☐ 130 ☐ 135
☐ 140 ☐ 145 ☐ 150 ☐ 155 ☐ 160 ☐ 165 ☐ 170 ☐ 175 ☐ 180

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65
☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100 ☐ 105 ☐ 110 ☐ 115 ☐ 120 ☐ 125 ☐ 130 ☐ 135
☐ 140 ☐ 145 ☐ 150 ☐ 155 ☐ 160 ☐ 165 ☐ 170 ☐ 175 ☐ 180

E. IF ROM DOES NOT CONFORM TO THE NORMAL RANGE OF MOTION IDENTIFIED ABOVE BUT IS NORMAL FOR THIS VETERAN *(for reasons other than a shoulder or arm condition, such as age, body habitus, neurologic disease)*, EXPLAIN:

SECTION V - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING

5A. IS THE VETERAN ABLE TO PERFORM REPETITIVE-USE TESTING WITH 3 REPETITIONS?

☐ YES ☐ NO

IF UNABLE, PROVIDE REASON:

IF VETERAN IS UNABLE TO PERFORM REPETITIVE-USE TESTING, SKIP TO SECTION VI.

IF VETERAN IS ABLE TO PERFORM REPETITIVE-USE TESTING, MEASURE AND REPORT ROM AFTER A MINIMUM OF 3 REPETITIONS.

5B. RIGHT SHOULDER POST-TEST ROM

Select where flexion ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65
☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100 ☐ 105 ☐ 110 ☐ 115 ☐ 120 ☐ 125 ☐ 130 ☐ 135
☐ 140 ☐ 145 ☐ 150 ☐ 155 ☐ 160 ☐ 165 ☐ 170 ☐ 175 ☐ 180

Select where abduction ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65
☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100 ☐ 105 ☐ 110 ☐ 115 ☐ 120 ☐ 125 ☐ 130 ☐ 135
☐ 140 ☐ 145 ☐ 150 ☐ 155 ☐ 160 ☐ 165 ☐ 170 ☐ 175 ☐ 180

SECTION V - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING *(Continued)*

5C. LEFT SHOULDER POST-TEST ROM

Select where flexion ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65
☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100 ☐ 105 ☐ 110 ☐ 115 ☐ 120 ☐ 125 ☐ 130 ☐ 135
☐ 140 ☐ 145 ☐ 150 ☐ 155 ☐ 160 ☐ 165 ☐ 170 ☐ 175 ☐ 180

Select where abduction ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65
☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100 ☐ 105 ☐ 110 ☐ 115 ☐ 120 ☐ 125 ☐ 130 ☐ 135
☐ 140 ☐ 145 ☐ 150 ☐ 155 ☐ 160 ☐ 165 ☐ 170 ☐ 175 ☐ 180

SECTION VI - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION IN ROM

THE FOLLOWING SECTION ADDRESSES REASONS FOR FUNCTIONAL LOSS, IF PRESENT, AND ADDITIONAL LOSS OF ROM AFTER REPETITIVE-USE TESTING, IF PRESENT. THE VA DEFINES FUNCTIONAL LOSS AS THE INABILITY TO PERFORM NORMAL WORKING MOVEMENTS OF THE BODY WITH NORMAL EXCURSION, STRENGTH, SPEED, COORDINATION AND/OR ENDURANCE.

6A. DOES THE VETERAN HAVE ADDITIONAL LIMITATION IN ROM OF THE SHOULDER AND ARM FOLLOWING REPETITIVE-USE TESTING?

☐ YES ☐ NO

6B. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS AND/OR FUNCTIONAL IMPAIRMENT OF THE SHOULDER AND ARM?

☐ YES ☐ NO

6C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT AND/OR ADDITIONAL LIMITATION OF ROM OF THE SHOULDER AND ARM AFTER REPETITIVE USE, INDICATE THE CONTRIBUTING FACTORS OF DISABILITY BELOW *(check all that apply and indicate side affected)*:

☐ NO FUNCTIONAL LOSS FOR RIGHT UPPER EXTREMITY
☐ NO FUNCTIONAL LOSS FOR LEFT UPPER EXTREMITY

☐ LESS MOVEMENT THAN NORMAL	☐ Right	☐ Left	☐ Both
☐ MORE MOVEMENT THAN NORMAL	☐ Right	☐ Left	☐ Both
☐ WEAKENED MOVEMENT	☐ Right	☐ Left	☐ Both
☐ EXCESS FATIGABILITY	☐ Right	☐ Left	☐ Both
☐ INCOORDINATION, IMPAIRED ABILITY TO EXECUTE SKILLED MOVEMENTS SMOOTHLY	☐ Right	☐ Left	☐ Both
☐ PAIN ON MOVEMENT	☐ Right	☐ Left	☐ Both
☐ SWELLING	☐ Right	☐ Left	☐ Both
☐ DEFORMITY	☐ Right	☐ Left	☐ Both
☐ ATROPHY OF DISUSE	☐ Right	☐ Left	☐ Both

SECTION VII - PAIN *(pain on palpation)*

7A. DOES THE VETERAN HAVE LOCALIZED TENDERNESS OR PAIN ON PALPATION OF JOINTS/SOFT TISSUE/BICEPS TENDON OF EITHER SHOULDER?

☐ YES ☐ NO IF YES, SHOULDER AFFECTED: ☐ Right ☐ Left ☐ Both

7B. DOES THE VETERAN HAVE GUARDING OF EITHER SHOULDER?

☐ YES ☐ NO IF YES, SHOULDER AFFECTED: ☐ Right ☐ Left ☐ Both

SECTION VIII - MUSCLE STRENGTH TESTING

8. 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

SHOULDER ABDUCTION	Right	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
SHOULDER FORWARD FLEXION:	Right	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5

SECTION IX - ANKYLOSIS

9. DOES THE VETERAN HAVE ANKYLOSIS OF THE GLENOHUMERAL ARTICULATION (SHOULDER JOINT)?

☐ YES ☐ NO

IF YES, INDICATE SEVERITY AND SIDE AFFECTED:

☐ ABDUCTION TO 60 DEGREES; CAN REACH MOUTH AND HEAD	☐ Right	☐ Left	☐ Both
☐ ABDUCTION LIMITED TO BETWEEN 60 AND 25 DEGREES	☐ Right	☐ Left	☐ Both
☐ ABDUCTION LIMITED TO 25 DEGREES FROM THE SIDE	☐ Right	☐ Left	☐ Both

SECTION X - SPECIFIC TESTS FOR ROTATOR CUFF CONDITIONS

10A. HAWKINS' IMPINGEMENT TEST *(Forward flex the arm to 90 degrees with the elbow bent to 90 degrees. Internally rotate arm. Pain on internal rotation indicates a positive test; may signify rotator cuff tendinopathy or tear)*

☐ POSITIVE ☐ NEGATIVE ☐ UNABLE TO PERFORM ☐ N/A

IF POSITIVE, SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

10B. EMPTY-CAN TEST *(Abduct arm to 90 degrees and forward flex 30 degrees. Patient turns thumbs down and resists downward force applied by the examiner. Weakness indicates a positive test; may indicate rotator cuff pathology, including supraspinatus tendinopathy or tear)*

☐ POSITIVE ☐ NEGATIVE ☐ UNABLE TO PERFORM ☐ N/A

IF POSITIVE, SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

10C. EXTERNAL ROTATION/INFRASPINATUS STRENGTH TEST *(Patient holds arms at side with elbow flexed 90 degrees. Patient externally rotates against resistance.. Weakness indicates a positive test; may be associated with infraspinatus tendinopathy or tear)*

☐ POSITIVE ☐ NEGATIVE ☐ UNABLE TO PERFORM ☐ N/A

IF POSITIVE, SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

10D. LIFT-OFF SUBSCAPULARIS TEST *(Patient internally rotates arm behind lower back, pushes against examiner's hand. Weakness indicates a positive test; may indicate subscapularis tendinopathy or tear)*

☐ POSITIVE ☐ NEGATIVE ☐ UNABLE TO PERFORM ☐ N/A

IF POSITIVE, SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

SECTION XI - HISTORY AND SPECIFIC TESTS FOR INSTABILITY/DISLOCATION/LABRAL PATHOLOGY

11A. IS THERE A HISTORY OF MECHANICAL SYMPTOMS *(clicking, catching, etc.)*?

☐ YES ☐ NO IF YES, SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

11B. IS THERE A HISTORY OF RECURRENT DISLOCATION (subluxation) OF THE GLENOHUMERAL (scapulohumeral) JOINT?

☐ YES ☐ NO IF YES, INDICATE FREQUENCY, SEVERITY AND SIDE AFFECTED *(check all that apply):*

☐ INFREQUENT EPISODES	☐ Right	☐ Left	☐ Both
☐ FREQUENT EPISODES	☐ Right	☐ Left	☐ Both
☐ GUARDING OF MOVEMENT ONLY AT SHOULDER LEVEL	☐ Right	☐ Left	☐ Both
☐ GUARDING OF ALL ARM MOVEMENTS	☐ Right	☐ Left	☐ Both

11C. CRANK APPREHENSION AND RELOCATION TEST *(With patient supine, abduct patient's arm to 90 degrees and flex elbow 90 degrees. Pain and sense of instability with further external rotation may indicate shoulder instability)*

☐ POSITIVE ☐ NEGATIVE ☐ UNABLE TO PERFORM ☐ N/A

IF POSITIVE, SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

SECTION XII - HISTORY AND SPECIFIC TESTS FOR CLAVICLE, SCAPULA, ACROMIOCLAVICULAR (AC) JOINT AND STERNOCLAVICULAR JOINT CONDITIONS

12A. DOES THE VETERAN HAVE AN AC JOINT CONDITION OR ANY OTHER IMPAIRMENT OF THE CLAVICLE OR SCAPULA?

☐ YES ☐ NO

IF YES, INDICATE SEVERITY AND SIDE AFFECTED

☐ MALUNION OF CLAVICLE OR SCAPULA	☐ Right	☐ Left	☐ Both
☐ NONUNION OF CLAVICLE OR SCAPULA WITHOUT LOOSE MOVEMENT	☐ Right	☐ Left	☐ Both
☐ NONUNION OF CLAVICLE OR SCAPULA WITH LOOSE MOVEMENT	☐ Right	☐ Left	☐ Both
☐ DISLOCATION (ACROMIOCLAVICULAR SEPARATION OR STERNOCLAVICULAR DISLOCATION)	☐ Right	☐ Left	☐ Both
☐ OTHER *(Describe)* _____	☐ Right	☐ Left	☐ Both

12B. IS THERE TENDERNESS ON PALPATION OF THE AC JOINT?

☐ YES ☐ NO IF YES, INDICATE SIDE: ☐ Right ☐ Left ☐ Both

12C. CROSS-BODY ADDUCTION TEST *(Passively adduct arm across the patient's body toward the contralateral shoulder. Pain may indicate acromioclavicular joint pathology)*

☐ POSITIVE ☐ NEGATIVE ☐ UNABLE TO PERFORM ☐ N/A

IF POSITIVE, SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

SECTION XIII - JOINT REPLACEMENT AND/OR OTHER SURGICAL PROCEDURES

13A. HAS THE VETERAN HAD A TOTAL SHOULDER JOINT REPLACEMENT?

☐ YES ☐ NO

IF YES, INDICATE SIDE AND SEVERITY OF RESIDUALS

☐ RIGHT SHOULDER

DATE OF SURGERY: _____

RESIDUALS:

☐ NONE

☐ INTERMEDIATE DEGREES OF RESIDUAL WEAKNESS, PAIN AND/OR LIMITATION OF MOTION

☐ CHRONIC RESIDUALS CONSISTING OF SEVERE PAINFUL MOTION AND/OR WEAKNESS

☐ OTHER (Describe) _____

☐ LEFT SHOULDER

DATE OF SURGERY: _____

RESIDUALS:

☐ NONE

☐ INTERMEDIATE DEGREES OF RESIDUAL WEAKNESS, PAIN AND/OR LIMITATION OF MOTION

☐ CHRONIC RESIDUALS CONSISTING OF SEVERE PAINFUL MOTION AND/OR WEAKNESS

☐ OTHER (Describe) _____

13B. HAS THE VETERAN HAD ARTHROSCOPIC OR OTHER SHOULDER SURGERY?

☐ YES ☐ NO IF YES, INDICATE SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

DATE AND TYPE OF SURGERY:

13C. DOES THE VETERAN HAVE ANY RESIDUAL SIGNS AND/OR SYMPTOMS DUE TO ARTHROSCOPIC OR OTHER SHOULDER SURGERY?

☐ YES ☐ NO IF YES, INDICATE SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

IF YES, DESCRIBE RESIDUALS:

SECTION XIV - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

14A. DOES THE VETERAN HAVE ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION 1, DIAGNOSIS?

☐ YES ☐ NO

IF YES, ARE ANY OF THE SCARS PAINFUL/OR UNSTABLE, OR IS THE TOTAL AREA OF ALL RELATED SCARS GREATER THAN 39 SQUARE cm *(6 square inches)*?

☐ YES ☐ NO

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

14B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION 1, DIAGNOSIS?

☐ YES ☐ NO IF YES, DESCRIBE *(Brief summary)*:

SECTION XV - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

15. DUE TO THE VETERAN'S SHOULDER AND/OR ARM CONDITIONS, 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 upper extremity include grasping, manipulation, etc)*

☐ YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROSTHESIS WOULD EQUALLLY SERVE THE VETERAN.

☐ NO

IF YES, INDICATE EXTREMITY(IES) *(check all extremities for which this applies):*

☐ Right upper ☐ Left upper

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

SECTION XVI - DIAGNOSTIC TESTING

NOTE: The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

16A. HAVE IMAGING STUDIES OF THE SHOULDER BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, IS DEGENERATIVE OR TRAUMATIC ARTHRITIS DOCUMENTED?

☐ YES ☐ NO

IF YES, INDICATE SHOULDER:

☐ Right ☐ Left ☐ Both

16B. 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 XVII - FUNCTIONAL IMPACT

17. DOES THE VETERAN'S SHOULDER AND/OR ARM CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

IF YES, DESCRIBE THE IMPACT OF EACH OF THE VETERAN'S SHOULDER AND/OR ARM CONDITIONS PROVIDING ONE OR MORE EXAMPLES:

SECTION XVIII - REMARKS

18. REMARKS *(If any)*

SECTION XIX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

19A. PHYSICIAN'S SIGNATURE	19B. PHYSICIAN'S PRINTED NAME	19C. DATE SIGNED

19D. PHYSICIAN'S PHONE AND FAX NUMBER	19E. PHYSICIAN'S MEDICAL LICENSE NUMBER	19F. 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 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 30 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.