

CRANIAL NERVES DISEASES  
DISABILITY BENEFITS QUESTIONNAIRE

Name of Patient/Veteran

Patient/Veteran's Social Security Number

Date of examination:

**IMPORTANT** - THE DEPARTMENT OF VETERANS AFFAIRS (VA) **WILL NOT PAY OR REIMBURSE** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM.

Note - The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the Veteran's application. VA reserves the right to confirm the authenticity of ALL completed questionnaires. **It is intended that this questionnaire will be completed by the Veteran's healthcare provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

☐ Veteran/Claimant☐ Third party (please list name(s) of organization(s) or individual(s))☐ Other: please describe

Are you a VA Healthcare provider?

☐ Yes☐ No

Is the Veteran regularly seen as a patient in your clinic?

☐ Yes☐ No

Was the Veteran examined in person?

☐ Yes☐ No

If no, how was the examination conducted?

## EVIDENCE REVIEW

Evidence reviewed:

☐ No records were reviewed☐ Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

## SECTION I - DIAGNOSIS

1A. Does the Veteran now have or has he or she ever been diagnosed with a cranial nerve condition? (This is the condition the Veteran is claiming or for which an exam has been requested)

☐ Yes☐ No

NOTE: Disabilities from conditions involving cranial nerves I, II, III, IV, VI, and VII are addressed in other questionnaires, including Eye, Hearing Loss and Tinnitus, and Loss of Smell and Taste; if those cranial nerves are involved, the appropriate questionnaire(s) should be completed in addition or lieu of this Questionnaire.

1B. If yes, provide only diagnoses that pertain to cranial nerve conditions:

Diagnosis #1 -

ICD Code:

Date of diagnosis:

Diagnosis #2 -

ICD Code:

Date of diagnosis:

Diagnosis #3 -

ICD Code:

Date of diagnosis:

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

## SECTION II - MEDICAL HISTORY

2A. Describe the history (including etiology, onset and course) of the Veteran's cranial nerve condition (brief summary):

2B. Indicate the cranial nerves affected by the Veteran's condition (check all that apply):

- ☐ Cranial Nerve I (olfactory) (If checked, complete the Loss of Sense of Smell and Taste DBQ)
- ☐ Cranial Nerves II - IV, VI (If checked, complete the Eye Conditions DBQ)
- ☐ Cranial Nerve V (trigeminal)
- ☐ Cranial Nerve VII (facial)
- ☐ Cranial Nerve VIII (If checked, complete the Hearing Loss and Tinnitus DBQ)
- ☐ Cranial Nerve IX (glossopharyngeal)
- ☐ Cranial Nerve X (vagus)
- ☐ Cranial Nerve XI (spinal accessory)
- ☐ Cranial Nerve XII (hypoglossal)

### SECTION III - FINDINGS, SIGNS AND SYMPTOMS

3. Does the Veteran have findings, signs or symptoms attributable to any conditions affecting cranial nerves, V, VII, and/or IX-XII?

☐ Yes ☐ No (If "Yes," indicate symptoms (check all that apply))

☐ A. Constant pain, at times excruciating (if checked, indicate location and severity):

Upper face, eye and/or forehead

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Mid face

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Lower face

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Side of mouth and throat

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

☐ B. Intermittent pain (if checked indicate severity):

Upper face, eye and/or forehead

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Mid face

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Lower face

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Side of mouth and throat

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

☐ C. Dull pain (if checked, indicate location and severity):

Upper face, eye and/or forehead

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Mid face

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Lower face

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Side of mouth and throat

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

☐ D. Paresthesias and/or dysesthesias (if checked, indicate location and severity):

Upper face, eye and/or forehead

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Mid face

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Lower face

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Side of mouth and throat

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

☐ E. Numbness (if checked, indicate location and severity):

Upper face, eye and/or forehead

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Mid face

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Lower face

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

Side of mouth and throat

Right: ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Mild ☐ Moderate ☐ Severe

☐ F. Difficulty chewing (If checked, indicate severity): ☐ Mild ☐ Moderate ☐ Severe

☐ G. Difficulty swallowing (If checked, indicate severity): ☐ Mild ☐ Moderate ☐ Severe

☐ H. Difficulty speaking (If checked, indicate severity): ☐ Mild ☐ Moderate ☐ Severe

☐ I. Increased salivation (If checked, indicate severity): ☐ Mild ☐ Moderate ☐ Severe

☐ J. Decreased salivation (If checked, indicate severity): ☐ Mild ☐ Moderate ☐ Severe

☐ K. Gastrointestinal symptoms (If checked, indicate severity): ☐ Mild ☐ Moderate ☐ Severe

☐ L. Other symptoms (If checked, indicate severity): ☐ Mild ☐ Moderate ☐ Severe

Describe:

**SECTION IV - MUSCLE STRENGTH TESTING**

4. Muscle strength testing (Rate strength using the following levels to estimate strength of muscle groups. This summary provides useful information for VA purposes)

☐ All normal

A. Cranial nerve V: (Motor: muscles of mastication; clench jaw, palpate masseter, temporalis)

Right: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

Left: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

B. Cranial nerve VII, upper portion of face: (Motor: muscles of facial expression, shuts eyes tightly)

Right: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

Left: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

C. Cranial nerve VII, lower portion of face: (Motor: muscles of facial expression; grins)

Right: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

Left: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

D. Cranial nerve IX, X: (Motor: swallow, cough, palate elevation; "say ah", gag reflex if indicated)

Right: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

Left: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

E. Cranial nerve XI: (Motor: trapezius, sternocleidomastoid; shoulder shrug, turn head against resistance)

Right: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

Left: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

F. Cranial nerve XII: (Motor: protrude tongue, move tongue from side to side)

Right: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

Left: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

**SECTION V - SENSORY EXAM**

5A. Provide results for sensation testing to light touch for facial sensation:

☐ All normal

Cranial nerve V:

Upper face and forehead

Right: ☐ Normal ☐ Decreased ☐ Absent

Left: ☐ Normal ☐ Decreased ☐ Absent

Mid face

Right: ☐ Normal ☐ Decreased ☐ Absent

Left: ☐ Normal ☐ Decreased ☐ Absent

Lower face

Right: ☐ Normal ☐ Decreased ☐ Absent

Left: ☐ Normal ☐ Decreased ☐ Absent

**SECTION VI - CRANIAL NERVE SUMMARY EVALUATION**

6A. Indicate the cranial nerve(s) affected. For each nerve, indicate severity ("degree of paralysis"), basing the responses on symptoms and findings from the above exam. This section provides an estimation of the severity of the Veteran's cranial nerve condition, which is useful for VA purposes.

NOTE: For VA purposes, the term "incomplete paralysis" indicates a degree of lost or impaired function substantially less than the description of complete paralysis that is given below with each nerve, whether due to a varied level of the nerve lesion or to partial regeneration.

☐ Cranial nerve V (trigeminal)

Right: ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete

Left: ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete

☐ Cranial nerve VII (facial)

Right:	<input type="radio"/> Not affected	<input type="radio"/> Incomplete, moderate	<input type="radio"/> Incomplete, severe	<input type="radio"/> Complete
Left:	<input type="radio"/> Not affected	<input type="radio"/> Incomplete, moderate	<input type="radio"/> Incomplete, severe	<input type="radio"/> Complete

☐ Cranial nerve IX (glossopharyngeal)

Right:	<input type="radio"/> Not affected	<input type="radio"/> Incomplete, moderate	<input type="radio"/> Incomplete, severe	<input type="radio"/> Complete
Left:	<input type="radio"/> Not affected	<input type="radio"/> Incomplete, moderate	<input type="radio"/> Incomplete, severe	<input type="radio"/> Complete

☐ Cranial nerve X (vagus)

Right:	<input type="radio"/> Not affected	<input type="radio"/> Incomplete, moderate	<input type="radio"/> Incomplete, severe	<input type="radio"/> Complete
Left:	<input type="radio"/> Not affected	<input type="radio"/> Incomplete, moderate	<input type="radio"/> Incomplete, severe	<input type="radio"/> Complete

☐ Cranial nerve XI (spinal accessory)

Right:	<input type="radio"/> Not affected	<input type="radio"/> Incomplete, moderate	<input type="radio"/> Incomplete, severe	<input type="radio"/> Complete
Left:	<input type="radio"/> Not affected	<input type="radio"/> Incomplete, moderate	<input type="radio"/> Incomplete, severe	<input type="radio"/> Complete

☐ Cranial nerve XII (hypoglossal)

Right:	<input type="radio"/> Not affected	<input type="radio"/> Incomplete, moderate	<input type="radio"/> Incomplete, severe	<input type="radio"/> Complete
Left:	<input type="radio"/> Not affected	<input type="radio"/> Incomplete, moderate	<input type="radio"/> Incomplete, severe	<input type="radio"/> Complete

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

7A. 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):

7B. Does the Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis section?

☐ Yes ☐ No If yes, also complete the appropriate dermatological questionnaire.

7C. Comments, if any:

## SECTION VIII - DIAGNOSTIC TESTING

NOTE - For the purpose of this examination, diagnostic or imaging studies are usually not required to diagnose specific cranial nerve conditions in the appropriate clinical setting.

8A. Have clinically relevant diagnostic imaging studies or other diagnostic procedures been performed or reviewed in conjunction with this examination?

☐ Yes ☐ No

(If "Yes," provide type of study, date and results)

8B. Are there any other clinically relevant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

☐ Yes ☐ No

(If "Yes," provide type of test or procedure, date and results - brief summary)

8C. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

### SECTION IX - 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.

9A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?

☐ Yes ☐ No

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

### SECTION X - REMARKS

10A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

### SECTION XI - EXAMINER'S CERTIFICATION AND SIGNATURE

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

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

11A. Examiner's signature:

11B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

11C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

11D. Date Signed:

11E. Examiner's phone/fax numbers:

11F. National Provider Identifier (NPI) number:

11G. Medical license number and state:

11H. Examiner's address: