Department of Veterans Affairs

EYE CONDITIONS
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

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

1A. DOES THE VETERAN CURRENTLY HAVE AN EYE CONDITION (other than congenital or developmental errors of refraction)?

◯ Yes ◯ No (If "Yes," provide only diagnoses 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 OR PRIOR DIAGNOSES THAT PERTAIN TO EYE CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. 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 or worse	◯ 10/200	◯ 15/200	◯ 20/200	◯ 20/100	◯ 20/70	◯ 20/50	◯ 20/40	◯ 20/20 or better
LEFT:	◯ 5/200 or worse	◯ 10/200	◯ 15/200	◯ 20/200	◯ 20/100	◯ 20/70	◯ 20/50	◯ 20/40	◯ 20/20 or better

b. Corrected distance:

RIGHT:	◯ 5/200 or worse	◯ 10/200	◯ 15/200	◯ 20/200	◯ 20/100	◯ 20/70	◯ 20/50	◯ 20/40	◯ 20/20 or better
LEFT:	◯ 5/200 or worse	◯ 10/200	◯ 15/200	◯ 20/200	◯ 20/100	◯ 20/70	◯ 20/50	◯ 20/40	◯ 20/20 or better

c. Uncorrected Near (Reading):

RIGHT:	◯ 5/200 or worse	◯ 10/200	◯ 15/200	◯ 20/200	◯ 20/100	◯ 20/70	◯ 20/50	◯ 20/40	◯ 20/20 or better
LEFT:	◯ 5/200 or worse	◯ 10/200	◯ 15/200	◯ 20/200	◯ 20/100	◯ 20/70	◯ 20/50	◯ 20/40	◯ 20/20 or better

d. Corrected Near (Reading):

RIGHT: ◯ 5/200 or worse ◯ 10/200 ◯ 15/200 ◯ 20/200 ◯ 20/100 ◯ 20/70 ◯ 20/50 ◯ 20/40 ◯ 20/20 or better

LEFT: ◯ 5/200 or worse ◯ 10/200 ◯ 15/200 ◯ 20/200 ◯ 20/100 ◯ 20/70 ◯ 20/50 ◯ 20/40 ◯ 20/20 or better

2. DIFFERENCE IN CORRECTED VISUAL ACUITY FOR DISTANCE AND NEAR VISION

a. 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 2b through 2d)

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

Second recording of corrected distance vision:

RIGHT: ◯ 5/200 or worse ◯ 10/200 ◯ 15/200 ◯ 20/200 ◯ 20/100 ◯ 20/70 ◯ 20/50 ◯ 20/40 ◯ 20/20 or better

LEFT: ◯ 5/200 or worse ◯ 10/200 ◯ 15/200 ◯ 20/200 ◯ 20/100 ◯ 20/70 ◯ 20/50 ◯ 20/40 ◯ 20/20 or better

Second recording of corrected near vision:

RIGHT: ◯ 5/200 or worse ◯ 10/200 ◯ 15/200 ◯ 20/200 ◯ 20/100 ◯ 20/70 ◯ 20/50 ◯ 20/40 ◯ 20/20 or better

LEFT: ◯ 5/200 or worse ◯ 10/200 ◯ 15/200 ◯ 20/200 ◯ 20/100 ◯ 20/70 ◯ 20/50 ◯ 20/40 ◯ 20/20 or better

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

d. 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 pupillary defect present? ◯ Yes ◯ No

(If "Yes," indicate affected eye): ◯ Right ◯ Left ◯ Both

☐ d. Other (Describe): _____

Eye affected ◯ Right ◯ Left ◯ Both

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

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

◯ Yes ◯ No (If "Yes," complete items 4b through 4f)

b. Does the Veteran have anatomical loss of either eye? ◯ Yes ◯ No

If "Yes," indicate affected eye: ◯ Right ◯ Left ◯ Both

If "Yes," is the Veteran able to wear an ocular prosthesis? ◯ Yes ◯ No

If "No," provide reason: _____

c. 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

d. 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

e. 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

f. 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

a. Does the Veteran have a corneal irregularity that results in severe irregular astigmatism?

◯ Yes ◯ No (If "Yes," complete items 5b and 5c)

b. 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

c. Was the corrected visual acuity determined using contact lenses? ◯ Yes ◯ No

If "No," explain: _____

6. DIPLOPIA

a. Does the Veteran have diplopia (double vision)? ◯ Yes ◯ No (If "Yes," complete items 6b through 6e)

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

NOTE: For VA purposes, examiners must use either a Goldmann perimeter chart or the Tangent Screen method identifying the four major quadrants (upward, downward, left lateral, and right lateral) and the central fields (20 degrees or less).

c. 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

d. Indicate frequency of the diplopia: ◯ Constant ◯ Occasional

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

e. Is the diplopia correctable with standard spectacle correction? ◯ Yes ◯ No

If "No," 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. Slit Lamp:

◯ Normal Bilaterally ◯ Abnormal (If Abnormal, complete items 8b through 8g)

b. External exam/lids/lashes:

Right: ◯ Normal ◯ Other (Describe): _____

Left: ◯ Normal ◯ Other (Describe): _____

c. Conjunctiva/sclera:

Right: ◯ Normal ◯ Other (Describe): _____

Left: ◯ Normal ◯ Other (Describe): _____

d. Cornea:

Right: ◯ Normal ◯ Other (Describe): _____

Left: ◯ Normal ◯ Other (Describe): _____

e. Anterior chamber:

Right: ◯ Normal ◯ Other (Describe): _____

Left: ◯ Normal ◯ Other (Describe): _____

f. Iris:

Right: ◯ Normal ◯ Other (Describe): _____

Left: ◯ Normal ◯ Other (Describe): _____

g. Lens:

Right: ◯ Normal ◯ Other (Describe): _____

Left: ◯ Normal ◯ Other (Describe): _____

9. INTERNAL EYE EXAM (FUNDUS)

a. Fundus:

◯ Normal bilaterally ◯ Abnormal (If Abnormal, complete items 9b through 9f)

b. Optic disc:

Right: ◯ Normal ◯ Other (Describe): _____

Left: ◯ Normal ◯ Other (Describe): _____

c. Macula:

Right: ◯ Normal ◯ Other (Describe): _____

Left: ◯ Normal ◯ Other (Describe): _____

d. Vessels

Right: ◯ Normal ◯ Other (Describe): _____

Left: ◯ Normal ◯ Other (Describe): _____

e. Vitreous

Right: ◯ Normal ◯ Other (Describe): _____

Left: ◯ Normal ◯ Other (Describe): _____

f. Periphery

Right: ◯ Normal ◯ Other (Describe): _____

Left: ◯ Normal ◯ Other (Describe): _____

10. VISUAL FIELDS

a. Does the Veteran have a documented visual field defect?

◯ Yes ◯ No (If "Yes," complete items 10b through 10f)

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 documented for at least 16 meridians 22½-degrees apart for each eye. 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, and the results must be documented on the examination report.

b. 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): _____

c. Does the Veteran have contraction of a visual field? ◯ Yes ◯ No (If "Yes," complete the following chart):

Meridian	Normal Degrees	Right Eye (OD) Actual Degrees (Cannot exceed the normal degrees)	Left Eye (OS) Actual Degrees (Cannot exceed the normal degrees)
Up (90° OD /90° OS)	45		
Up Temporally (45° OD/135° OS)	55		
Temporally (0° OD /180° OS)	85		
Down Temporally (315° OD /225° OS)	85		
Down (270° OD /270° OS)	65		

Down Nasally (225° OD /315° OS)	50		
Nasally (180° OD /0° OS)	60		
Up Nasally (135° OD /45° OS)	55		

d. 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 (Describe): _____ ◯ Right ◯ Left ◯ Both

e. 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

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

◯ Yes ◯ No

SECTION IV - EYE CONDITIONS

1. Does the Veteran have any of the following eye conditions?

◯ Yes (If "Yes," check all that apply) ◯ No (If "No," proceed to Section V)

- ☐ External Eye Conditions, including the eyelash, eyelid, and eyebrow (Complete item 2 below)
- ☐ Lacrimal System Conditions, including Dry Eye Syndrome (Complete item 3 below)
- ☐ Cornea/Conjunctiva Conditions (Complete item 4 below)
- ☐ Glaucoma (Complete item 5 below)
- ☐ Uveal Tract Conditions (Complete item 6 below)
- ☐ Lens Conditions, including Cataracts (Complete item 7 below)
- ☐ Retina, Macula, or Vitreous Conditions (Complete item 8 below)
- ☐ Neuro-Ophthalmic Conditions (Complete item 9 below)
- ☐ Ocular Neoplasms (Complete item 10 below)
- ☐ Trauma/Hemorrhage (Complete item 11 below)
- ☐ Other Eye Conditions (Complete item 12 below)

2. EXTERNAL EYE CONDITION, INCLUDING THE EYELASH, EYELID, AND EYEBROW

a. Indicate the Veteran's condition and side affected (check all that apply):

- ☐ Ectropion ◯ Right ◯ Left ◯ Both
- ☐ Entropion ◯ Right ◯ Left ◯ Both
- ☐ Lagophthalmos ◯ Right ◯ Left ◯ Both
- ☐ Complete loss of eyebrows ◯ Right ◯ Left ◯ Both

☐ Complete loss of eyelashes ◯ Right ◯ Left ◯ Both

☐ Partial or complete loss of eyelid ◯ Right ◯ Left ◯ Both

☐ Pterygium ◯ Right ◯ Left ◯ Both

☐ Pinguecula ◯ Right ◯ Left ◯ Both

☐ Symblepharon ◯ 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 an external eye condition?

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

If "Yes," specify the external eye condition(s) responsible for visual impairment

_____

If "No," explain:

_____

3. LACRIMAL SYSTEM CONDITIONS, including Dry Eye Syndrome

a. Does the Veteran have a disorder of the lacrimal apparatus, to include epiphora, dacryocystitis, etc.?

◯ Yes ◯ No

If "Yes," specify condition and side affected: _____ ◯ Right ◯ Left ◯ Both

b. Is the Veteran's decrease in visual acuity or other visual impairment attributable to a lacrimal system condition?

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

If "Yes," specify the lacrimal system condition(s) responsible for visual impairment: _____

If "No," explain: _____

c. Does the Veteran have dry eye syndrome? ◯ Yes ◯ No (If "Yes," please complete items 3d through 3h)

d. Indicate the eye affected by dry eye syndrome: ◯ Right ◯ Left ◯ Both

e. Date dry eye syndrome began: _____

f. Has the Veteran ever had elective procedures, such as laser eye surgery (e.g. LASIK)? ◯ Yes ◯ No

If "Yes," specify which eye, procedure, and date: ◯ Right ◯ Left ◯ Both

Name or description of procedure: _____

Date(s) of procedure: _____

Did dry eye syndrome begin after the elective procedure? ◯ Yes ◯ No

g. Indicate the types of treatment used to treat dry eye syndrome:

☐ No treatment

☐ Over-the-counter artificial tear drops

☐ Prescription medications

☐ Special contact lenses

☐ Plugs to block the tear ducts through which tears drain

☐ Surgical procedures

Name or description of surgical procedure: _____

Date(s) of surgery: _____

☐ Other (Describe): _____

h. Is the Veteran's decrease in visual acuity or other visual impairment attributable to dry eye syndrome?

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

If "Yes," specify the dry eye syndrome condition(s) responsible for visual impairment: _____

If "No," explain: _____

4. CORNEA/CONJUNCTIVA CONDITIONS

a. Indicate the Veteran's condition and side affected:

☐ Keratopathy ◯ Right ◯ Left ◯ Both

☐ Trachomatous conjunctivitis

(Indicate if it is active or inactive for each eye)

☐ Right ◯ Active ◯ Inactive

☐ Left ◯ Active ◯ Inactive

☐ Chronic conjunctivitis (non trachomatous)

(Indicate if it is active or inactive for each eye)

☐ Right ◯ Active ◯ Inactive

☐ Left ◯ Active ◯ Inactive

☐ Keratoconus ◯ Right ◯ Left ◯ Both

☐ Corneal transplant ◯ Right ◯ Left ◯ Both

☐ Other (describe): _____ ◯ Right ◯ Left ◯ Both

b. Is the Veteran's decrease in visual acuity or other visual impairment attributable to a corneal condition?

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

If "Yes," specify corneal condition(s) responsible for visual impairment: _____

If "No," explain: _____

c. If the Veteran had a corneal transplant, please indicate the current residual(s).

(Check all that apply):

☐ No current residuals

☐ Pain ◯ Right ◯ Left ◯ Both

☐ Photophobia ◯ Right ◯ Left ◯ Both

☐ Glare sensitivity ◯ Right ◯ Left ◯ Both

☐ Other, (describe): _____ ◯ Right ◯ Left ◯ Both

5. 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," 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: _____

6. UVEAL TRACT CONDITIONS

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

☐ Choroidopathy (including uveitis, iritis, cyclitis, or choroiditis) ◯ Right ◯ Left ◯ Both

☐ Scleritis ◯ Right ◯ Left ◯ Both

☐ Tuberculosis of the eye (indicate if it is active or inactive for each eye) ☐ Right ◯ Active ◯ Inactive

☐ Left ◯ Active ◯ Inactive

☐ Other (Describe): _____ ◯ Right ◯ Left ◯ Both

b. Is the Veteran's decrease in visual acuity or other visual impairment, if present, attributable to an uveal tract eye condition?

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

If "Yes," specify uveal tract condition(s) responsible for visual impairment: _____

If "No," explain: _____

7. LENS CONDITIONS, INCLUDING CATARACTS

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 a replacement intraocular lens? (pseudophakia) ◯ Yes ◯ No If "Yes," indicate eye ◯ Right ◯ Left ◯ Both

b. Is there aphakia or dislocation of the crystalline 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 condition in this section responsible for visual impairment: _____

If "No," explain: _____

8. RETINA, MACULA, OR VITREOUS CONDITIONS

a. Indicate retina, macula, or vitreous condition and eye affected:

☐ Diabetic retinopathy (including proliferative and nonproliferative types) ◯ Right ◯ Left ◯ Both

☐ Retinopathy, not otherwise specified ◯ Right ◯ Left ◯ Both

☐ Maculopathy, not otherwise specified ◯ Right ◯ Left ◯ Both

☐ Localized retinal scars, atrophy, or irregularities, that are centrally located and result in an irregular, duplicated, enlarged, or diminished image ◯ Right ◯ Left ◯ Both

☐ Detachment of retina ◯ Right ◯ Left ◯ Both

☐ Retinal dystrophy (including retinitis pigmentosa, wet or dry macular degeneration, early-onset macular degeneration, rod and/or cone dystrophy) ◯ Right ◯ Left ◯ Both

☐ Other (Describe): _____ ◯ Right ◯ Left ◯ Both

b. Is the Veteran's decrease in visual acuity or other visual impairment attributable to a retina, macula, or vitreous condition?

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

If "Yes," specify the retina, macula, or vitreous condition(s) responsible for visual impairment: _____

If "No," explain: _____

9. NEURO-OPHTHALMIC CONDITIONS

a. Indicate the Veteran's condition and side affected:

☐ Ptosis ◯ Right ◯ Left ◯ Both

☐ Optic neuropathy ◯ Right ◯ Left ◯ Both

☐ Paralysis of accommodation due to neuropathy of the oculomotor nerve (3rd cranial nerve) ◯ Right ◯ Left ◯ Both

☐ Post-chiasmal disorders ◯ Right ◯ Left ◯ Both

If there is a post-chiasmal disorder, indicate the underlying cause:

☐ Cerebrovascular accident (CVA)

☐ Demyelinating disease

☐ Intracranial mass/tumor

☐ Traumatic Brain Injury (TBI)

☐ Alzheimer's Disease

☐ Other - Specify the underlying neurologic condition

(for example: Jakob-Creutzfeldt disease, etc.): _____

b. Does the Veteran have nystagmus? ◯ Yes ◯ No

If "Yes," is it central? ◯ Yes ◯ No

c. Is the Veteran's decrease in visual acuity or other visual impairment attributable to a neuro-ophthalmic condition?

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

If "Yes," specify the neuro-ophthalmic condition(s) responsible for visual impairment: _____

If "No," explain: _____

10. OCULAR NEOPLASMS

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

☐ Malignant neoplasm of the eye, orbit, or adnexa (excluding skin) ◯ Right ◯ Left ◯ Both

☐ Benign neoplasm of the eye, orbit, or adnexa (excluding skin) ◯ Right ◯ Left ◯ Both

☐ Other (Describe): _____ ◯ Right ◯ Left ◯ Both

b. Is the Veteran's decrease in visual acuity or other visual impairment attributable to an eye neoplasm condition?

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

If "Yes," specify the neoplasm condition responsible for visual impairment: _____

If "No," explain: _____

c. Is the neoplasm active or in remission?

◯ Active ◯ Remission

d. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm of the eye, orbit, or adnexa (excluding skin) 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 (more extensive than enucleation)

Name or description of surgical procedure: _____

Date(s) of surgery: _____

☐ Radiation therapy (to include, but not limited to x-ray therapy more extensive than to the area of the eye)

Date of most recent treatment: _____

Date of completion of treatment or anticipated date of completion: _____

☐ Systemic chemotherapy

Date of most recent treatment: _____

Date of completion of treatment or anticipated date of completion: _____

☐ Other therapeutic procedure

Name or description of procedure: _____

Date of most recent procedure: _____

e. Does the Veteran currently have any residual conditions or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?

◯ Yes ◯ No

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

11. TRAUMA / HEMORRHAGE

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

☐ Intraocular hemorrhage	◯ Right	◯ Left	◯ Both
☐ Unhealed eye injury, inclusive of orbital trauma as well as penetrating and non-penetrating eye injury	◯ Right	◯ Left	◯ Both
☐ Other (Describe): _____	◯ Right	◯ Left	◯ Both

b. Is the Veteran's decrease in visual acuity or other visual impairment attributable to an eye hemorrhage or trauma?

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

If "Yes," specify the hemorrhage or trauma condition responsible for visual impairment: _____

If "No," explain: _____

12. OTHER EYE CONDITION(S) NOT COVERED BY ITEMS 2 THROUGH 11

a. Does the Veteran have any other eye conditions, pertinent physical findings, complications, signs, and/or symptoms related to a current eye diagnosis?

◯ Yes ◯ No

If "Yes," describe:

b. Is the Veteran's decrease in visual acuity or other visual impairment attributable to this condition?

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

If "Yes," specify the condition(s) responsible for visual impairment: _____

If "No," explain: _____

SECTION V - SCARRING AND DISFIGUREMENT

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

◯ Yes ◯ No (If "Yes," complete appropriate dermatological DBQ)

SECTION VI - INCAPACITATING EPISODES

NOTE: For the purposes of evaluation under 38 CFR 4.79, an incapacitating episode is an eye condition serious enough to require a clinic visit to a provider specifically for treatment purposes. Examples of treatment may include but are not limited to: Systematic immunosuppressants or biologic agents; intravitreal or periocular injections; laser treatments; or other surgical interventions.

6A. During the past 12 months, has the Veteran had any incapacitating episodes attributable to an eye condition?

◯ Yes ◯ No

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

6B. Indicate the number of DOCUMENTED medical visits for treatment of an eye condition over the past 12 months:

◯ At least 1 but less than 3

◯ At least 3 but less than 5

◯ At least 5 but less than 7

◯ 7 or more

6C. Indicate the type of intervention that occurred during the incapacitating episode (Check all that apply):

☐ Systemic immunosuppressant or biologic agent (name of medication): _____

☐ Intravitreal or periocular injections (name of medication): _____

☐ Laser treatments _____

☐ Surgical intervention (Describe): _____

☐ Other (Describe): _____

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

8A. REMARKS (If any)

SECTION IX - 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.

9A. Examiner's signature:	9B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

9C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	9D. Date Signed:

9E. Examiner's phone/fax numbers:	9F. National Provider Identifier (NPI) number:	9G. Medical license number and state:

9H. Examiner's address: