Department of Veterans Affairs

HERNIAS (INCLUDING ABDOMINAL, INGUINAL AND FEMORAL HERNIAS) 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: These are condition(s) for which an evaluation has been requested on the 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 questionnaire:

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(s), explain your findings and reasons in the Remarks 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):

Note: For hiatal hernia, complete the Esophageal Disorders Questionnaire in lieu of this questionnaire.

☐ The Veteran does not have a current diagnosis associated with any claimed condition(s) listed above. (Explain your findings and reasons in the Remarks section)

☐ Femoral hernia ICD code: _____ Date of diagnosis: _____

☐ Incisional hernia ICD code: _____ Date of diagnosis: _____

☐ Inguinal hernia ICD code: _____ Date of diagnosis: _____

☐ Umbilical hernia ICD code: _____ Date of diagnosis: _____

☐ Ventral hernia ICD code: _____ Date of diagnosis: _____

☐ Other (specify):

Other diagnosis #1: _____ ICD code: _____ Date of diagnosis: _____

Other diagnosis #2: _____ ICD code: _____ Date of diagnosis: _____

Other diagnosis #3: _____ ICD code: _____ Date of diagnosis: _____

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

SECTION II - MEDICAL HISTORY

2A. Describe the history, including onset and course, of the Veteran's hernia condition(s). Brief summary:

2B. Does the Veteran's treatment plan include taking daily prescribed medication for the diagnosed condition(s)?

◯ Yes ◯ No

If yes, list only those medications used for the diagnosed condition(s):

SECTION III - FEMORAL HERNIA

3A. Was surgery performed? ◯ Yes ◯ No

If yes, complete the following:

Date(s) of surgery: _____

Type(s) of surgery: _____

Indicate side: ◯ Right ◯ Left ◯ Both

If there are additional femoral hernia surgeries, list using above format:

3B. Is a current/recurrent hernia present upon examination or been documented? ◯ Yes ◯ No

If yes, complete the following:

Provide date and source a medical professional documented the hernia as present: _____

Indicate side: ◯ Right ◯ Left ◯ Both

Is the hernia repairable or irreparable?

Repairable: ◯ Right ◯ Left ◯ Both

Irreparable: ◯ Right ◯ Left ◯ Both

Note: When determining whether a hernia is repairable or irreparable, consider current medical guidance as to whether this type of hernia is typically able to be surgically repaired, any available medical records documenting that the hernia has been classified as repairable or irreparable, and any significant medical contraindications that could prohibit surgical repair.

If an irreparable hernia is present, complete the remainder of section III.

3C. Provide date and source a medical professional documented the hernia as irreparable:

Right: _____

Left: _____

Explanation of why hernia was determined to be irreparable:

Right:

Left:

3D. Indicate size of irreparable hernia:

☐ Size equal to 15 cm or greater in one dimension: ◯ Right ◯ Left ◯ Both

☐ Size equal to 3 cm or greater but less than 15 cm in one dimension: ◯ Right ◯ Left ◯ Both

☐ Size smaller than 3 cm: ◯ Right ◯ Left ◯ Both

Date size of hernia was documented and the source:

Right: _____

Left: _____

If there has been any clinically significant change in the size of the irreparable hernia, provide the side, size, the date the size was documented, and the source:

3E. Indicate if the Veteran has pain when performing any of the following due to an irreparable hernia:

☐ Activities of daily living (bathing, dressing, hygiene, and/or transfers): ◯ Right ◯ Left ◯ Both

☐ Bending over: ◯ Right ◯ Left ◯ Both

☐ Climbing stairs: ◯ Right ◯ Left ◯ Both

☐ Walking: ◯ Right ◯ Left ◯ Both

Has the pain been present for 12 months or more?

Right: ◯ Yes ◯ No

Left: ◯ Yes ◯ No

3F. Comments (if any):

SECTION IV - INGUINAL HERNIA

4A. Was surgery performed? ◯ Yes ◯ No

If yes, complete the following:

Date(s) of surgery: _____

Type(s) of surgery: _____

Indicate side: ◯ Right ◯ Left ◯ Both

If there are additional inguinal hernia surgeries, list using above format:

4B. Is a current/recurrent hernia present upon examination or been documented? ◯ Yes ◯ No

If yes, complete the following:

Provide date and source a medical professional documented the hernia as present: _____

Indicate side: ◯ Right ◯ Left ◯ Both

Is the hernia repairable or irreparable?

Repairable: ◯ Right ◯ Left ◯ Both

Irreparable: ◯ Right ◯ Left ◯ Both

Note: When determining whether a hernia is repairable or irreparable, consider current medical guidance as to whether this type of hernia is typically able to be surgically repaired, any available medical records documenting that the hernia has been classified as repairable or irreparable, and any significant medical contraindications that could prohibit surgical repair.

If an irreparable hernia is present, complete the remainder of section IV.

4C. Provide date and source a medical professional documented the hernia as irreparable:

Right: _____

Left: _____

Explanation of why hernia was determined to be irreparable:

Right:

Left:

4D. Indicate size of irreparable hernia:

- ☐ Size equal to 15 cm or greater in one dimension: ◯ Right ◯ Left ◯ Both
- ☐ Size equal to 3 cm or greater but less than 15 cm in one dimension: ◯ Right ◯ Left ◯ Both
- ☐ Size smaller than 3 cm: ◯ Right ◯ Left ◯ Both

Date size of hernia was documented and the source:

Right: _____

Left: _____

If there has been any clinically significant change in the size of the irreparable hernia, provide the side, size, the date the size was documented, and the source:

4E. Indicate if the Veteran has pain when performing any of the following due to an irreparable hernia:

- ☐ Activities of daily living (bathing, dressing, hygiene, and/or transfers): ◯ Right ◯ Left ◯ Both
- ☐ Bending over: ◯ Right ◯ Left ◯ Both
- ☐ Climbing stairs: ◯ Right ◯ Left ◯ Both
- ☐ Walking: ◯ Right ◯ Left ◯ Both

Has the pain been present for 12 months or more?

Right: ◯ Yes ◯ No

Left: ◯ Yes ◯ No

4F. Comments (if any):

SECTION V - UMBILICAL, VENTRAL, INCISIONAL, AND OTHER HERNIAS

5A. Was surgery performed? ◯ Yes ◯ No

If yes, complete the following:

Type of hernia: _____

Date(s) of surgery: _____

Type(s) of surgery: _____

5B. Is a current/recurrent hernia present upon examination or been documented? ◯ Yes ◯ No

If yes, complete the following:

Provide date and source a medical professional documented the hernia as present: _____

Is the hernia repairable or irreparable? ◯ Repairable ◯ Irreparable

Note: When determining whether a hernia is repairable or irreparable, consider current medical guidance as to whether this type of hernia is typically able to be surgically repaired, any available medical records documenting that the hernia has been classified as repairable or irreparable, and any significant medical contraindications that could prohibit surgical repair.

If an irreparable hernia is present, complete the remainder of section V.

5C. Provide date and source a medical professional documented the hernia as irreparable: _____

Explanation of why hernia was determined to be irreparable:

5D. Indicate size of irreparable hernia:

☐ Size equal to 15 cm or greater in one dimension

☐ Size equal to 3 cm or greater but less than 15 cm in one dimension

☐ Size smaller than 3 cm

Date size of hernia was documented and the source: _____

If there has been any clinically significant change in the size of the irreparable hernia, provide the size, the date the size was documented, and the source:

5E. Indicate if the Veteran has pain when performing any of the following due to an irreparable hernia:

☐ Activities of daily living (bathing, dressing, hygiene, and/or transfers)

☐ Bending over

☐ Climbing stairs

☐ Walking

Has the pain been present for 12 months or more?

◯ Yes ◯ No

5F. Comments (if any):

5G. If there are additional hernias, indicate using the format from 5A through 5E:

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

6A. 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):

6B. 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.

SECTION VII - DIAGNOSTIC TESTING

Note: If testing has been performed and reflects the Veteran's current condition, repeat testing is not required. Specific diagnostic testing is not required for hernia examination.

7A. Has the Veteran had clinically relevant diagnostic testing performed in conjunction with this examination?

◯ Yes ◯ No

If yes, provide test or procedure date and results (brief summary):

7B. 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 test or procedure date and results (brief summary):

7C. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

SECTION VIII - 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.

8A. 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 IX - REMARKS

9A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION X - 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.

10A. Examiner's signature:	10B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):
10C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	10D. Date Signed:
10E. Examiner's phone/fax numbers:	10F. National Provider Identifier (NPI) number:	10G. Medical license number and state:
10H. Examiner's address:	