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

Department of Veterans Affairs

HIP AND THIGH 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 HAVE A HIP AND THIGH CONDITION?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO HIP AND THIGH 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 HIP AND THIGH CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S HIP/THIGH CONDITION(S) *(brief summary)*

2B. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE AFFECTED JOINT(S)?

☐ YES ☐ NO *(If "Yes," document the veteran's description of the impact of flare-ups in his or her own words):*

SECTION III - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS

3. MEASURE ROM WITH A GONIOMETER, ROUNDING EACH MEASUREMENT TO THE NEAREST 5 DEGREES. REPORT INITIAL MEASUREMENTS BELOW

A. Right hip ROM

Check box at which flexion ends *(normal endpoint is 125 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 or greater

Check box at which extension ends *(normal endpoint is 0 degrees):*

☐ 0 ☐ 5 or greater

Is adduction lost beyond 10 degrees?

☐ YES ☐ NO

Is adduction limited such that the veteran cannot cross legs?

☐ YES ☐ NO

Is rotation limited such that the veteran cannot toe-out more than 15 degrees?

☐ YES ☐ NO

B. Left hip ROM

Check box at which flexion ends *(normal endpoint is 125 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 or greater

Check box at which extension ends *(normal endpoint is 0 degrees):*

☐ 0 ☐ 5 or greater

Is adduction lost beyond 10 degrees?

☐ YES ☐ NO

Is adduction limited such that the veteran cannot cross legs?

☐ YES ☐ NO

Is rotation limited such that the veteran cannot toe-out more than 15 degrees?

☐ YES ☐ NO

C. If ROM does not conform to the normal range of motion identified above but is normal for this veteran *(for reasons other than a hip condition, such as age, body habitus, neurologic disease)*, explain:

SECTION IV - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING

NOTE: For VA purposes, repetitive-use testing must also be performed. The VA has determined that 3 repetitions, at minimum, can serve as a representative test for the effect of repetitive use. Following initial ROM assessment, the clinician must perform repetitive-use testing and report post-test measurements.

4A. IS VETERAN ABLE TO PERFORM REPETITIVE-USE TESTING WITH 3 REPETITIONS?

☐ YES ☐ NO

(If "No," provide reason):

(If "Yes," skip to section 5)

(If veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions.)

4B. RIGHT HIP POST-TEST ROM

Check box at which post-test 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 or greater

Check box at which post-test extension ends:

☐ 0 ☐ 5 or greater

Is post-test adduction lost beyond 10 degrees?

☐ YES ☐ NO

Is post-test adduction limited such that the veteran cannot cross legs?

☐ YES ☐ NO

Is post-test rotation limited such that the veteran cannot toe-out more than 15 degrees?

☐ YES ☐ NO

4C. LEFT HIP POST-TEST ROM

Check box at which post-test 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 or greater

Check box at which post-test extension ends:

☐ 0 ☐ 5 or greater

Is post-test adduction lost beyond 10 degrees?

☐ YES ☐ NO

Is post-test adduction limited such that the veteran cannot cross legs?

☐ YES ☐ NO

Is post-test rotation limited such that the veteran cannot toe-out more than 15 degrees?

☐ YES ☐ NO

SECTION V - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION IN ROM

5A. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS AND/OR FUNCTIONAL IMPAIRMENT OF THE HIP AND THIGH?

☐ YES ☐ NO

5B. DOES THE VETERAN HAVE ADDITIONAL LIMITATION IN ROM OF THE HIP AND THIGH FOLLOWING REPETITIVE-USE TESTING?

☐ YES ☐ NO

5C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT AND/OR ADDITIONAL LIMITATION OF ROM OF THE HIP AND THIGH AFTER REPETITIVE USE, INDICATE THE CONTRIBUTING FACTORS OF DISABILITY BELOW *(check all that apply and indicate side affected):*

☐ NO FUNCTIONAL LOSS FOR RIGHT LOWER EXTREMITY

☐ NO FUNCTIONAL LOSS FOR LEFT LOWER EXTREMITY

Factor			
☐ 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
☐ INSTABILITY OF STATION	☐ Right	☐ Left	☐ Both
☐ DISTURBANCE OF LOCOMOTION	☐ Right	☐ Left	☐ Both
☐ INTERFERENCE WITH SITTING, STANDING AND OR WEIGHT-BEARING	☐ Right	☐ Left	☐ Both

SECTION VI - PAINFUL MOTION, TENDERNESS AND STRENGTH TESTING

6A. IS THERE OBJECTIVE EVIDENCE OF PAINFUL MOTION FOR EITHER HIP *(evidenced by visible behavior, such as facial expression, wincing, etc.)?*

☐ YES ☐ NO *(If "Yes," side affected):* ☐ Right ☐ Left ☐ Both

6B. DOES THE VETERAN HAVE LOCALIZED TENDERNESS OR PAIN TO PALPATION FOR JOINTS/SOFT TISSUE OF EITHER HIP?

☐ YES ☐ NO *(If "Yes," side affected):* ☐ Right ☐ Left ☐ Both

6C. STRENGTH TESTING - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

0/5 No muscle movement
1/5 Visible muscle movement, but no joint movement
2/5 No movement against gravity
3/5 No movement against resistance
4/5 Less than normal strength
5/5 Normal strength

Hip 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
Hip 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
Hip extension:	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 VII - ADDITIONAL CONDITIONS

7A. DOES THE VETERAN HAVE ANKYLOSIS, MALUNION OR NONUNION OF FEMUR, FLAIL HIP JOINT OR LEG LENGTH DISCREPANCY?

☐ YES ☐ NO *(If "Yes," complete Items 7B through 7E)*

7B. DOES THE VETERAN HAVE ANKYLOSIS OF EITHER HIP JOINT?

☐ YES ☐ NO *(If "Yes," indicate severity and side affected):*

☐ Favorable, in flexion at an angle between 20 and 40 degrees, and slight adduction or abduction
☐ Right ☐ Left ☐ Both

☐ Intermediate, between favorable and unfavorable
☐ Right ☐ Left ☐ Both

☐ Unfavorable, extremely unfavorable ankylosis, foot not reaching ground, crutches needed
☐ Right ☐ Left ☐ Both

7C. DOES THE VETERAN HAVE MALUNION OR NONUNION OF THE FEMUR?

☐ YES ☐ NO *(If "Yes," indicate severity and side affected):*

☐ Malunion with slight hip disability	☐ Right	☐ Left	☐ Both
☐ Malunion with moderate hip disability	☐ Right	☐ Left	☐ Both
☐ Malunion with marked hip disability	☐ Right	☐ Left	☐ Both
☐ Intertrochanteric fracture *(surgical neck)* with false joint	☐ Right	☐ Left	☐ Both
☐ Fracture of shaft or neck *(anatomical)*, resulting in nonunion without loose motion; weight-bearing preserved with aid of a brace	☐ Right	☐ Left	☐ Both
☐ Fracture of shaft or neck *(anatomical)*, with nonunion with loose motion; *(spiral or oblique fracture)*	☐ Right	☐ Left	☐ Both

NOTE - If impairment of the femur causes knee disability(ies), also complete the VA Form 21-0960M-9, Knee and Lower Leg Conditions Disability Benefits Questionnaire.

7D. DOES THE VETERAN HAVE A FLAIL HIP JOINT?

☐ YES ☐ NO *(If "Yes," indicate hip affected):* ☐ Right ☐ Left ☐ Both

7E. DOES THE VETERAN HAVE SHORTENING OF ANY BONES OF THE LOWER EXTREMITY *(leg length discrepancy)?*

☐ YES ☐ NO

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

Measurements: Right leg: ____________ ☐ cm ☐ inches Left leg: ____________ ☐ cm ☐ inches

SECTION VIII - JOINT REPLACEMENT AND/OR SURGICAL PROCEDURES

8A. HAS THE VETERAN HAD A TOTAL HIP JOINT REPLACEMENT?

☐ YES ☐ NO *(If "Yes," indicate side and severity of residuals*

☐ Right hip

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 hip

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: ____________

8B. HAS THE VETERAN HAD ARTHROSCOPIC OR OTHER HIP SURGERY?

☐ YES ☐ NO *(If "Yes," indicate side affected):* ☐ Right ☐ Left ☐ Both

Date and type of surgery: ____________

8C. DOES THE VETERAN HAVE ANY RESIDUAL SIGNS AND/OR SYMPTOMS DUE TO ARTHROSCOPIC OR OTHER HIP SURGERY?

☐ YES ☐ NO *(If "Yes," indicate side affected):* ☐ Right ☐ Left ☐ Both

(If "Yes," describe symptoms): ____________

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

9. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

☐ YES ☐ NO *(If "Yes," describe):*

SECTION X - ASSISTIVE DEVICES AND REMAINING FUNCTION OF THE EXTREMITIES

10A. 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 device(s) used (check all that apply and indicate frequency):

☐ Wheelchair Frequency of use: ☐ Occasional ☐ Regular ☐ Constant
☐ Brace(s) Frequency of use: ☐ Occasional ☐ Regular ☐ Constant
☐ Crutch(es) Frequency of use: ☐ Occasional ☐ Regular ☐ Constant
☐ Cane(s) Frequency of use: ☐ Occasional ☐ Regular ☐ Constant
☐ Walker Frequency of use: ☐ Occasional ☐ Regular ☐ Constant
☐ Other: ____________
Frequency of use: ☐ Occasional ☐ Regular ☐ Constant

(If "Yes," identify and describe each condition(s) causing the need for assistive device(s):

10B. DUE TO THE SERVICE-CONNECTED DISABLING CONDITION(S), 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., while functions for the lower extremity include balance and propulsion, etc.)*

☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the veteran
☐ No

(If "Yes," indicate extremity(ies)) (check all extremities for which this applies):

☐ Right upper ☐ Left upper ☐ Right lower ☐ Left lower

SECTION XI - DIAGNOSTIC TESTING

NOTE: The diagnosis of arthritis must be confirmed by imaging studies. Once arthritis has been documented, no further imaging studies are indicated, even if arthritis has worsened.

11A. HAVE IMAGING STUDIES OF THE HIP(S) BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

(If "Yes," is arthritis documented?)

☐ YES ☐ NO

(If "Yes," indicate hip)

☐ Right ☐ Left ☐ Both

11B. 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 XII - FUNCTIONAL IMPACT AND REMARKS

12. DOES THE VETERAN'S HIP/THIGH CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the veteran's hip/thigh conditions, providing one or more examples):*

13. REMARKS *(If any)*

SECTION XIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

14A. PHYSICIAN'S SIGNATURE	14B. PHYSICIAN'S PRINTED NAME	14C. DATE SIGNED

14D. PHYSICIAN'S PHONE NUMBER	14E. PHYSICIAN'S MEDICAL LICENSE NUMBER	14F. 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 required to obtain or retain benefits. 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.