OMB Control No. 2900-0778
Respondent Burden: 15 minutes

Department of Veterans Affairs

EAR CONDITIONS (INCLUDING VESTIBULAR AND INFECTIOUS) 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 OR HAS HE OR SHE HAD ANY EAR OR PERIPHERAL VESTIBULAR CONDITIONS?

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

1B. SELECT VETERAN'S CONDITION *(check all that apply)*:

☐ Meniere's syndrome or endolymphatic hydrops	ICD Code:	Date of Diagnosis:
☐ Peripheral vestibular disorder	ICD Code:	Date of Diagnosis:
☐ Benign Paroxysmal Positional Vertigo *(BPPV)*	ICD Code:	Date of Diagnosis:
☐ Chronic otitis externa	ICD Code:	Date of Diagnosis:
☐ Chronic suppurative otitis media	ICD Code:	Date of Diagnosis:
☐ Chronic nonsuppurative otitis media *(serous otitis media)*	ICD Code:	Date of Diagnosis:
☐ Mastoiditis	ICD Code:	Date of Diagnosis:
☐ Cholesteatoma	ICD Code:	Date of Diagnosis:
(If checked, a VA Form 21-0960N-5, Hearing Loss and Tinnitus Questionnaire must ALSO be completed.) ☐ Otosclerosis	ICD Code:	Date of Diagnosis:
(If checked, a VA Form 21-0960N-5, Hearing Loss and Tinnitus Questionnaire must be completed in lieu of this Questionnaire.) ☐ Benign neoplasm of the ear *(other than skin only)*	ICD Code:	Date of Diagnosis:
☐ Malignant neoplasm of the ear *(other than skin only)* *(If checked, complete a VA Form 21-0960O-1, Tumors and Neoplasms Disability Benefits Questionnaire in lieu of this Questionnaire)*	ICD Code:	Date of Diagnosis:
☐ Other, specify:		
Other, diagnosis #1:_____	ICD Code:	Date of Diagnosis:
Other, diagnosis #2:_____	ICD Code:	Date of Diagnosis:

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO EAR OR PERIPHERAL VESTIBULAR CONDITIONS, LIST USING ABOVE FORMAT:

NOTE: If the Veteran has hearing loss or tinnitus attributable to any ear condition listed above, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed.

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S EAR OR PERIPHERAL VESTIBULAR CONDITIONS *(brief summary)*:

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITION?

☐ YES ☐ NO *(If "Yes," list only those medications used for the diagnosed condition):*

SECTION III - VESTIBULAR CONDITIONS

3. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS, OR SYMPTOMS ATTRIBUTABLE TO MENIERE'S SYNDROME *(ENDOLYMPHATIC HYDROPS)*, A PERIPHERAL VESTIBULAR CONDITION OR ANOTHER DIAGNOSED CONDITION FROM SECTION 1, DIAGNOSIS?

☐ YES ☐ NO

(If "Yes," check all that apply):

☐ Hearing impairment with vertigo
(If checked, indicate frequency): ☐ Less than once a month ☐ 1 to 4 times per month ☐ More than once weekly
(Indicate duration of episodes): ☐ < 1 hour ☐ 1 to 24 hours ☐ > 24 hours

☐ Hearing impairment with attacks of vertigo and cerebellar gait
(If checked, indicate frequency): ☐ Less than once a month ☐ 1 to 4 times per month ☐ More than once weekly
(Indicate duration of episodes): ☐ < 1 hour ☐ 1 to 24 hours ☐ > 24 hours

☐ Tinnitus, unilateral or bilateral
(If checked, indicate frequency): ☐ Less than once a month ☐ 1 to 4 times per month ☐ More than once weekly
(Indicate duration of episodes): ☐ < 1 hour ☐ 1 to 24 hours ☐ > 24 hours

☐ Vertigo
(If checked, indicate frequency): ☐ Less than once a month ☐ 1 to 4 times per month ☐ More than once weekly
(Indicate duration of episodes): ☐ < 1 hour ☐ 1 to 24 hours ☐ > 24 hours

☐ Staggering
(If checked, indicate frequency): ☐ Less than once a month ☐ 1 to 4 times per month ☐ More than once weekly
(Indicate duration of episodes): ☐ < 1 hour ☐ 1 to 24 hours ☐ > 24 hours

☐ Nausea
(If checked, indicate frequency): ☐ Less than once a month ☐ 1 to 4 times per month ☐ More than once weekly
(Indicate duration of episodes): ☐ < 1 hour ☐ 1 to 24 hours ☐ > 24 hours

☐ Vomiting
(If checked, indicate frequency): ☐ Less than once a month ☐ 1 to 4 times per month ☐ More than once weekly
(Indicate duration of episodes): ☐ < 1 hour ☐ 1 to 24 hours ☐ > 24 hours

☐ Hearing impairment and/or tinnitus
(If checked, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed)

☐ Other, describe: _____

SECTION IV - INFECTIOUS, INFLAMMATORY AND OTHER EAR CONDITIONS

4A. DOES THE VETERAN HAVE ANY OF THE FOLLOWING FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO CHRONIC EAR INFECTION, INFLAMMATION, CHOLESTEATOMA OR ANY OF THE DIAGNOSES IN SECTION 1?

☐ YES ☐ NO

(If "Yes," check all that apply):

☐ Swelling
(If checked, describe): _____

☐ Dry scaly discharge

☐ Serous discharge

☐ Itching

☐ Effusion

☐ Active suppuration

☐ Aural polyps

☐ Hearing impairment and/or tinnitus
(If checked, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed)

☐ Facial nerve paralysis
(If checked, ALSO complete Cranial Nerves Questionnaire)

☐ Bone loss of skull
(If checked, indicate severity):
- ☐ Area lost smaller than an American quarter (4.619 cm2)
- ☐ Area lost greater than an American quarter but smaller than a 50-cent piece
- ☐ Area lost larger than an American 50-cent piece (7.55 cm2)

☐ Requiring frequent and prolonged treatment
(If checked, describe type and durations of treatment): _____

☐ Other, describe: _____

4B. DOES THE VETERAN HAVE A BENIGN NEOPLASM OF THE EAR (OTHER THAN SKIN ONLY, SUCH AS KELOID OR OSTEOMA) THAT CAUSES ANY IMPAIRMENT OF FUNCTION?

☐ YES ☐ NO

(If "Yes," describe impairment of function caused by this condition):

SECTION V - SURGICAL TREATMENT

5A. HAS THE VETERAN HAD SURGICAL TREATMENT FOR ANY EAR CONDITION?

☐ YES ☐ NO *(If "Yes," indicate type of surgery):*

Date: _____

Side affected: ☐ Right ☐ Left ☐ Both

5B. DOES THE VETERAN HAVE ANY RESIDUALS AS A RESULT OF THE SURGERY?

☐ YES ☐ NO *(If "Yes," describe):*

SECTION VI - PHYSICAL EXAM

6A. EXTERNAL EAR

- ☐ Exam or external ear not indicated
- ☐ Normal
- ☐ Deformity of auricle, with loss of less than one-third of substance
  (If checked, specify side): ☐ Right ☐ Left
- ☐ Deformity of auricle, with loss of one-third or more of the substance
  (If checked, specify side): ☐ Right ☐ Left
- ☐ Complete loss of auricle
  (If checked, specify side): ☐ Right ☐ Left
- ☐ Other abnormality, describe:

6B. EAR CANAL:

- ☐ Exam of ear canal not indicated
- ☐ Normal
- ☐ Abnormal, describe:

6C. TYMPANIC MEMBRANE:

- ☐ Exam of tympanic membrane not indicated
- ☐ Normal
- ☐ Perforated tympanic membrane
  (If checked, specify side): ☐ Right ☐ Left
- ☐ Evidence of a healed tympanic membrane perforation
  (If checked, specify side): ☐ Right ☐ Left
- ☐ Other abnormality, describe:

6D. GAIT:

- ☐ Exam of gait not indicated
- ☐ Normal
- ☐ Unsteady, describe:

  _____
- ☐ Other abnormality, describe:

6E. RHOMBERG TEST:

- ☐ Exam using this test not indicated
- ☐ Normal or negative
- ☐ Abnormal or positive for unsteadiness

6F. DIX HALLPIKE TEST (NYLEN-BARANY TEST) FOR VERTIGO

- ☐ Exam using this test not indicated
- ☐ Normal, no vertigo or nystagmus during test
- ☐ Abnormal, vertigo or nystagmus during test, describe:

6G. LIMB COORDINATION TEST (FINGER-NOSE-FINGER)

- ☐ Exam using this test not indicated
- ☐ Normal
- ☐ Abnormal, describe:

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

7A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, SIGNS AND/OR SYMPTOMS?

☐ YES ☐ NO *(If "Yes," describe (brief summary)):*

7B. DOES THE VETERAN HAVE ANY SCARS (SURGICAL OR OTHERWISE) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

(If "Yes," are any of the scars painful and/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 a Scars Questionnaire.)*

SECTION VIII - DIAGNOSTIC TESTING

NOTE: If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report. The diagnosis of gastric or duodenal ulcer or stenosis can be made by upper gastrointestinal imaging series or endoscopy.

8A. HAVE DIAGNOSTIC IMAGING STUDIES OR OTHER DIAGNOSTIC PROCEDURES BEEN PERFORMED?

☐ YES ☐ NO

(If "Yes," check all that apply):

☐ Magnetic resonance imaging (MRI) Date: _____ Results: _____

☐ Computerized axial tomography (CT) Date: _____ Results: _____

☐ Electronystagmography (ENG) Date: _____ Results: _____

☐ Other, specify: _____

Date: _____ Results: _____

8B. HAS THE VETERAN HAD AN AUDIOGRAM?

☐ YES ☐ NO

(If "Yes," attach or provide results):

_____

(If the Veteran has hearing loss or tinnitus, a Hearing and Tinnitus exam must ALSO be scheduled.)

8C. 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 IX - FUNCTIONAL IMPACT

9. DO ANY OF THE VETERAN'S EAR OR PERIPHERAL VESTIBULAR CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

(If "Yes," describe impact of each of the Veteran's ear or peripheral vestibular conditions, providing one or more examples):

SECTION X - REMARKS

10. REMARKS *(If any)*

SECTION XI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

11A. PHYSICIAN'S SIGNATURE	11B. PHYSICIAN'S PRINTED NAME	11C. DATE SIGNED

11D. PHYSICIAN'S PHONE AND FAX NUMBER	11E. PHYSICIAN'S MEDICAL LICENSE NUMBER	11F. 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.)

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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 15 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.