



**HERNIAS (INCLUDING ABDOMINAL, INGUINAL AND FEMORAL HERNIAS)
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 BEFORE COMPLETING THIS FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
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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 NOW HAVE OR HAS HE OR SHE EVER HAD ANY HERNIA CONDITIONS? *(This is the condition the veteran is claiming or for which an exam has been requested)*

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

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

<input type="checkbox"/> INGUINAL HERNIA <i>(If checked, complete Section IV.1)</i>	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> FEMORAL HERNIA <i>(If checked, complete Section IV.2)</i>	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> VENTRAL HERNIA <i>(If checked, complete Section IV.3)</i>	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> OTHER <i>(Specify):</i>		
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 INGUINAL, FEMORAL OR VENTRAL HERNIAS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL RECORD REVIEW

2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARATION OF THIS REPORT:

C-FILE (VA ONLY)
 OTHER, DESCRIBE: _____

SECTION III - MEDICAL HISTORY

3. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S HERNIA CONDITIONS *(brief summary):*

SECTION IV - HERNIA CONDITIONS

1. INGUINAL HERNIA

A. SURGICAL STATUS *(check all that apply):*

Surgery performed *(If "Yes," indicate side, date and type of surgery):*

Right: Date and type of surgery: _____
 Left: Date and type of surgery: _____

No previous surgery but hernia appears operable and remediable *(If checked, indicate side):* Right: Left:

Irremediable, provide reason: _____ *(If checked, indicate side):* Right: Left:

Inoperable, provide reason: _____ *(If checked, indicate side):* Right: Left:

Recurrent hernia following surgical repair *(If checked, indicate status of postoperative recurrent hernia):*

Recurrent hernia appears operable and remediable *(If checked, indicate side):* Right: Left:

Irremediable, provide reason: _____ *(If checked, indicate side):* Right: Left:

Inoperable, provide reason: _____ *(If checked, indicate side):* Right: Left:

B. EXAM

Right: <input type="checkbox"/> No hernia detected	<input type="checkbox"/> No true hernia protrusion	<input type="checkbox"/> Small hernia	<input type="checkbox"/> Large hernia
Left: <input type="checkbox"/> No hernia detected	<input type="checkbox"/> No true hernia protrusion	<input type="checkbox"/> Small hernia	<input type="checkbox"/> Large hernia

C. ABILITY TO BE REDUCED

Right: <input type="checkbox"/> Readily reducible	<input type="checkbox"/> Not readily reducible
Left: <input type="checkbox"/> Readily reducible	<input type="checkbox"/> Not readily reducible

D. INDICATION FOR SUPPORT *(Is there an indication for a supporting belt?)*

YES NO *(If "Yes," can the hernia be supported by truss or belt?):*

Yes, can be well supported by truss or belt *(If checked, indicate side well supported):* Right: Left:

Not well supported by truss or belt *(If checked, indicate side not well supported):* Right: Left:

N/A, no truss or belt tried or used

SECTION IV - HERNIA CONDITIONS (Continued)

2. FEMORAL HERNIA

A. SURGICAL STATUS (check all that apply):

- Surgery performed (If "Yes," indicate side, date and type of surgery):
 Right: Date and type of surgery: _____
 Left: Date and type of surgery: _____
- No previous surgery but hernia appears operable and remediable (If checked, indicate side): Right: Left:
- Irremediable, provide reason: _____ (If checked, indicate side): Right: Left:
- Inoperable, provide reason: _____ (If checked, indicate side): Right: Left:
- Recurrent hernia following surgical repair (If checked, indicate status of postoperative recurrent hernia):
 Recurrent hernia appears operable and remediable (If checked, indicate side): Right: Left:
 Irremediable, provide reason: _____ (If checked, indicate side): Right: Left:
 Inoperable, provide reason: _____ (If checked, indicate side): Right: Left:

B. EXAM

- Right: No hernia detected No true hernia protrusion Small hernia Large hernia
 Left: No hernia detected No true hernia protrusion Small hernia Large hernia

C. ABILITY TO BE REDUCED

- Right: Readily reducible Not readily reducible
 Left: Readily reducible Not readily reducible

D. INDICATION FOR SUPPORT (Is there an indication for a supporting belt?)

- YES NO (If "Yes," can the hernia be supported by truss or belt?):
 Yes, can be well supported by truss or belt (If checked, indicate side well supported): Right: Left:
 Not well supported by truss or belt (If checked, indicate side not well supported): Right: Left:
 N/A, no truss or belt tried or used

3. VENTRAL HERNIA

A. SURGICAL STATUS (check all that apply):

- Surgery performed (If "Yes," indicate date and type of surgery):
 Date and type of surgery: _____
- No previous surgery but hernia appears operable and remediable
- Irremediable, provide reason: _____
- Inoperable, provide reason: _____
- Recurrent hernia following surgical repair (If checked, indicate status of postoperative recurrent hernia):
 Recurrent hernia appears operable and remediable (If checked, indicate side):
 Irremediable, provide reason: _____
 Inoperable, provide reason: _____

B. EXAM (check all that apply):

- No hernia detected
 Healed postoperative ventral hernia repair
 Healed postoperative wounds with weakening of abdominal wall
 Small ventral hernia
 Large ventral hernia
 Massive, persistent, severe diastasis of recti muscles
 Extensive diffuse destruction or weakening of muscular and fascial support of abdominal wall so as to be inoperable
 Other, describe: _____

C. INDICATION FOR SUPPORT (Is there an indication for a supporting belt?)

- YES NO (If "Yes," can the hernia be supported by truss or belt?):
 Yes, can be well supported by truss or belt
 Not well supported by truss or belt
 N/A, no truss or belt tried or used

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

5A. DOES THE VETERAN HAVE ANY SCARS (*surgical or otherwise*) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

YES NO

(If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than or equal to 39 square cm (6 square inches)?)

YES NO (If "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)

5B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

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

SECTION VI - DIAGNOSTIC TESTING

NOTE - If testing has been performed and reflects veteran's current condition, repeat testing is not required. Specific diagnostic testing is not required for hernia examination.

6. ARE THERE ANY SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

YES NO (If "Yes," provide type of test or procedure, date and results - brief summary):

SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S HERNIA CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

YES NO (If "Yes," describe the impact of each of the veteran's hernia condition(s), providing one or more examples):

SECTION VIII - REMARKS

8. REMARKS (If any):

SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9A. PHYSICIAN'S SIGNATURE

9B. PHYSICIAN'S PRINTED NAME

9C. DATE SIGNED

9D. PHYSICIAN'S PHONE AND FAX NUMBERS

9E. PHYSICIAN'S MEDICAL LICENSE NUMBER

9F. 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.benefits.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 voluntary. 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.