Veterans Affairs Canada | Anciens Combattants Canada

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File No.:	Decision No.:
	Service No(s).:

Medical Questionnaire: Musculoskeletal Upper Limb and Chest Conditions

Family name:	Given name:	Date of Birth:
Name of Physician:		Date of Examination:

MEDICAL DIAGNOSIS(ES) OF CLAIMED/PENSIONED CONDITION(S) REQUIRING EXAMINATION:

1. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

2. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

3. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

Very specific information is required by Veterans Affairs Canada to evaluate and assess a client's claimed pensioned condition(s). As this information may not generally form part of the clinical history, please help us to collect this information by answering the following questions.

Please complete applicable sections only.

If additional recording space is required, please use the "additional comments" sheet.

PLEASE ATTACH/FORWARD COPIES OF RELEVANT REPORTS (E.G. DIAGNOSTIC, CONSULTATION, OPERATIVE, LABORATORY, HOSPITAL DISCHARGE SUMMARIES)

Upper Extremity Function:

*Please complete this section **if** the client has a condition that affects the function(s) of the upper limb as a whole (e.g. spinal cord injury or disease which affects the function of one or both upper limbs, complex regional pain syndromes Type 1 and Type 2 of the upper limb(s), compartment syndrome of the upper limb(s), thoracic outlet syndrome of the upper limb(s), peripheral neurological conditions of the upper limb(s)).*

Does the upper limb condition affect the client's ability to use the upper limb efficiently for feeding, dressing, writing and other daily tasks? ◯ Yes ◯ No
If yes, please describe:

Dexterity/Coordination:

Does the upper limb condition affect the client's dexterity/coordination? ◯ Yes ◯ No
If yes, what dexterity/coordination changes does the client experience? (check all which apply)

- ☐ handwriting changes
- ☐ difficulty manipulating small/fine objects (e.g. tying shoe laces, setting a watch)
- ☐ difficulty manipulating larger objects (e.g. turning door handles)
- ☐ other, please specify: _____

Grip Strength:

Does the upper limb condition affect the client's grip strength? ◯ Yes ◯ No
If yes, what objects does the client have difficulty gripping?

Pain and Fatigue:

Does the upper limb condition cause excessive pain and/or fatigue with use? ◯ Yes ◯ No
If yes, describe when the excessive pain and fatigue occurs:

◯ within 10 minutes ◯ within 1 hour ◯ toward the end of the day ◯ other _____

Is paresthesia and/or numbness present? ◯ Yes ◯ No
If yes, please describe:

Family name:	Given name:	File No.:

SHOULDER CONDITION(S):

MEDICAL HISTORY: Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors.

Shoulder injury(ies): ◯ Yes ◯ No
If yes, please describe and include dates:

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No
If yes, indicate for which condition and indicate the nature of the test/consultation, and the appointment date (if known).

TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response), details of relevant surgery/hospitalization and other therapies (e.g. physiotherapy).

COMPLICATIONS:
Are there any complications resulting from the claimed/pensioned condition(s)? ◯ Yes ◯ No
If yes, please provide details:

Fracture Status: (if applicable)

Please indicate the site and type of fracture(s):

1.
2.
3.

Is/are the above noted fracture(s) well healed?

1. ◯ Yes ◯ No
2. ◯ Yes ◯ No
3. ◯ Yes ◯ No

If no, please describe noting non-union, malunion, angulation and displacement.

Osteomyelitis: (if applicable)

Has the client had osteomyelitis? ◯ Yes ◯ No

If yes, please comment on sites, activity, dates and outcomes:

PLEASE FILL OUT PHYSICAL EXAMINATION SECTION ON PAGES 8 AND 9

Family name:	Given name:	File No.:

ELBOW CONDITION(S):

MEDICAL HISTORY: Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors.

Elbow injury(ies): ◯ Yes ◯ No
If yes, please describe and include dates:

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No
If yes, indicate for which condition and indicate the nature of the test/consultation, and the appointment date (if known).

TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response), details of relevant surgery/hospitalization and other therapies (e.g. physiotherapy).

COMPLICATIONS:
Are there any complications resulting from the claimed/pensioned condition(s)? ◯ Yes ◯ No
If yes, please provide details:

Fracture Status: (if applicable)

Please indicate the site and type of fracture(s):

1.
2.
3.

Is/are the above noted fracture(s) well healed?

1. ◯ Yes ◯ No
2. ◯ Yes ◯ No
3. ◯ Yes ◯ No

If **no**, please describe noting non-union, malunion, angulation and displacement.

Osteomyelitis: (if applicable)

Has the client had osteomyelitis? ◯ Yes ◯ No

If yes, please comment on sites, activity, dates and outcomes:

PLEASE FILL OUT PHYSICAL EXAMINATION SECTION ON PAGES 8 AND 9

Family name:	Given name:	File No.:

WRIST CONDITION(S):

MEDICAL HISTORY: Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors.

Wrist injury(ies): ◯ Yes ◯ No
If yes, please describe and include dates:

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No
If yes, indicate for which condition and indicate the nature of the test/consultation, and the appointment date (if known).

TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response), details of relevant surgery/hospitalization and other therapies (e.g. physiotherapy).

COMPLICATIONS:
Are there any complications resulting from the claimed/pensioned condition(s)? ◯ Yes ◯ No
If yes, please provide details:

Fracture Status: (if applicable)

Please indicate the site and type of fracture(s):

1.
2.
3.

Is/are the above noted fracture(s) well healed?

1. ◯ Yes ◯ No
2. ◯ Yes ◯ No
3. ◯ Yes ◯ No

If no, please describe noting non-union, malunion, angulation and displacement.

Osteomyelitis: (if applicable)

Has the client had osteomyelitis? ◯ Yes ◯ No

If yes, please comment on sites, activity, dates and outcomes:

PLEASE FILL OUT PHYSICAL EXAMINATION SECTION ON PAGES 8 AND 9

Family name:	Given name:	File No.:

THUMB/DIGIT CONDITION(S):

MEDICAL HISTORY: Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors.

Thumb/Digit injury(ies): ◯ Yes ◯ No
If yes, please describe and include dates:

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No
If yes, indicate for which condition and indicate the nature of the test/consultation, and the appointment date (if known).

TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response), details of relevant surgery/hospitalization and other therapies (e.g. physiotherapy).

COMPLICATIONS:
Are there any complications resulting from the claimed/pensioned condition(s)? ◯ Yes ◯ No
If yes, please provide details:

Fracture Status: (if applicable)

Please indicate the site and type of fracture(s):

1.
2.
3.

Is/are the above noted fracture(s) well healed?

1. ◯ Yes ◯ No
2. ◯ Yes ◯ No
3. ◯ Yes ◯ No

If no, please describe noting non-union, malunion, angulation and displacement.

Osteomyelitis: (if applicable)

Has the client had osteomyelitis? ◯ Yes ◯ No
If yes, please comment on sites, activity, dates and outcomes:

PLEASE FILL OUT PHYSICAL EXAMINATION SECTION ON PAGES 8 AND 9

Family name:	Given name:	File No.:

AMPUTATION(S):

MEDICAL HISTORY: Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors. Indicate the site of the amputation(s). Please be as specific as possible (e.g. above elbow amputation proximal to biceps tendon insertion). Indicate length of stump in centimeters.

Is/are there relevant injury(ies): ◯ Yes ◯ No
If **yes**, please describe and include dates:

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No
If yes, indicate for which condition and indicate the nature of the test/consultation, and the appointment date (if known).

TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response), details of relevant surgery/hospitalization and other therapies (e.g. physiotherapy). Indicate if a prosthetic is used and if so, describe type.

COMPLICATIONS:
Are there any complications resulting from the claimed/pensioned condition(s)? ◯ Yes ◯ No
If yes, please provide details:

PLEASE FILL OUT PHYSICAL EXAMIN ATION SECTION ON PAGES 8 AND 9

Family name:	Given name:	File No.:

MUSCULOSKELETAL CHEST CONDITION(S):

MEDICAL HISTORY: Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors.

Musculoskeletal Chest injury(ies): ◯ Yes ◯ No
If yes, please describe and include dates:

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No
If yes, indicate for which condition and indicate the nature of the test/consultation, and the appointment date (if known).

TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response), details of relevant surgery/hospitalization and other therapies (e.g. physiotherapy).

COMPLICATIONS:
Are there any complications resulting from the claimed/pensioned condition(s)? ◯ Yes ◯ No
If yes, please provide details:

Fracture Status: (if applicable)

Please indicate the site and type of fracture(s):

1.
2.
3.

Is/are the above noted fracture(s) well healed?

1. ◯ Yes ◯ No
2. ◯ Yes ◯ No
3. ◯ Yes ◯ No

If no, please describe noting non-union, malunion, angulation and displacement.

Osteomyelitis: (if applicable)

Has the client had osteomyelitis? ◯ Yes ◯ No
If yes, please comment on sites, activity, dates and outcomes:

PLEASE FILL OUT PHYSICAL EXAMINATION SECTION ON PAGES 8 AND 9

Family name:	Given name:	File No.:

PHYSICAL EXAMINATION: (fill out only portion applicable to the pensioned/claimed condition(s))

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Respiration _____

GENERAL APPEARANCE:

Please provide the following information where and if applicable for each pensioned/claimed condition:

Handedness: ◯ Right ◯ Left ◯ Both

ACTIVE Range Of Motion (ROM): (N = Normal)

Shoulder	**Right**	**Left**	**Describe any pain with movement:**
Flexion (forward elevation) (N = 170°)	_____ degrees	_____ degrees	_____
Extension (backward elevation) (N = 30°)	_____ degrees	_____ degrees	_____
Abduction (N = 180°)	_____ degrees	_____ degrees	_____
Adduction (N = 45°)	_____ degrees	_____ degrees	_____
External Rotation (N = 90°)	_____ degrees	_____ degrees	_____
Internal Rotation (N = 90°)	_____ degrees	_____ degrees	_____

Elbow and Forearm			
Flexion (N = 140°)	_____ degrees	_____ degrees	_____
Extension (N = 0°)	_____ degrees	_____ degrees	_____
Supination (N = 80°)	_____ degrees	_____ degrees	_____
Pronation (N = 80°)	_____ degrees	_____ degrees	_____

Wrist			
Flexion (palmar flexion) (N = 70°)	_____ degrees	_____ degrees	_____
Extension (dorsiflexion) (N = 60°)	_____ degrees	_____ degrees	_____
Ulnar deviation (N = 30°)	_____ degrees	_____ degrees	_____
Radial deviation (N = 20°)	_____ degrees	_____ degrees	_____

Thumb/digits

Describe any loss of ROM of the thumb/digits. Identify the affected joint and provide a measurement of active ROM in degrees for all planes of movement.

Family name:	Given name:	File No.:

Ankylosed or Flail Joints:

If a joint is/are ankylosed or flail, please indicate below:

a) Joint affected: _____ ☐ ankylosed _____ position in degrees ☐ flail
b) Joint affected: _____ ☐ ankylosed _____ position in degrees ☐ flail
c) Joint affected: _____ ☐ ankylosed _____ position in degrees ☐ flail

OTHER EXAMINATION FINDINGS: Describe any relevant examination findings.

IF ADLs ARE AFFECTED ON A CONTINUOUS BASIS, DESPITE OPTIMAL TREATMENT, PLEASE COMPLETE THE ADL SECTION.

OTHER PERTINENT FINDINGS: (i.e. other conditions that may be contributing to the client's impairment)
If there are other conditions contributing to the impairment, describe and indicate to what degree:

Physician's signature:	Is VAC to be invoiced? ◯ Yes ◯ No	Telephone No. ( )	Today's date:

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Activities of Daily Living (ADL) Questionnaire

Family name:	Given name:	Date of Birth:
Name of Physician:		Date of Examination:

IF APPLICABLE TO THE CLAIMED/PENSIONED CONDITION(S), PLEASE COMPLETE THIS SHEET

Activities of Daily Living:

Please describe the impact that the <u>pensioned conditions</u> have on Activities of Daily Living.

Select the description that <u>most accurately</u> reflects the client's current level of functioning for each of the following activities:

Activity	Independent	Independent (with aids)	Requires reminders, prompting and/or supervision in addition to minor assistance	Needs extensive assistance	Totally dependent
Eating	◯	◯	◯	◯	◯
Bathing	◯	◯	◯	◯	◯
Grooming	◯	◯	◯	◯	◯
Dressing	◯	◯	◯	◯	◯
Toiletting	◯	◯	◯	◯	◯
Transferring	◯	◯	◯	◯	◯

Please elaborate (list aids required, ability to sit/stand unaided during task, safety concerns, bed mobility, etc.):

Continence/Incontinence:

Select the description that <u>most accurately</u> reflects the client's current level of bladder and bowel control:

	Continent (No assistance needed)	Occassional nighttime incontinence (once a week or less)	Daytime incontinence (more than once per week)	Daytime (daily) incontinence (requiring protective padding)	Daytime (daily) incontinence (requiring intervention by others)	Total incontinence
Bladder	◯	◯	◯	◯	◯	◯
Bowel	◯	◯	◯	◯	◯	◯

Comment: Please note the number of incontinence pads used/day, if applicable.

Locomotion: Please comment on any difficulty with walking, provide walking distance, and list aids required.

Chronic Pain: Please comment on pain intensity, frequency, symptoms and response to treatment.

Comments: Please remember to note other contributing conditions.

Physician's signature:	Today's date:

Family name:	Given name:	File No.:

Additional Comments :

Physician's signature:	Today's date: