Veterans Affairs Canada | Anciens Combattants Canada

Protected information when completed.

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

Medical Questionnaire: Visual 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.

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

Injuries? ◯ Yes ◯ No **Describe (include dates)**

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

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

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:

Family name:	Given name:	File No.:

Visual Acuity:
Please record the best corrected distance visual acuity: _____ Left eye _____ Right eye

Diplopia:

Is diplopia present? ◯ Yes ◯ No
If yes,
is the diplopia ◯ constant or ◯ intermittent?

Please indicate the extent of the diplopia:

- ☐ one quadrant of upward gaze
- ☐ all directions of upward gaze
- ☐ one quadrant of downward gaze
- ☐ all directions of downward gaze
- ☐ one direction of sideways gaze
- ☐ both directions of sideways gaze
- ☐ all directions of gaze
- ☐ all range of near vision

Is the diplopia correctable with prism, and to what degree?

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

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Respiration _____

GENERAL APPEARANCE:

EXAMINATION FINDINGS: Describe any relevant examination findings.

OTHER PERTINENT FINDINGS: (i.e. other conditions that may be contributing to the client's impairment)

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

Family name:	Given name:	File No.:

Additional Comments:

Physician's signature:	Today's date: