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SECTION III - PHYSICAL EXAMINATION (Continued)

2. DIFFERENCE IN CORRECTED VISUAL ACUITY FOR DISTANCE AND NEAR VISION

Does the veteran have a difference equal to two or more lines on the Snellen test type chart or its equivalent between distance and near corrected vision, with the near vision being worse?

Yes No (If "Yes," complete Items 2A thru 2C)

a. Provide a second recording of corrected distance and near vision

Second recording of corrected distance vision:

RIGHT: 5/200 20/400 15/200 20/200 20/100 20/70 20/50 20/40 or better

LEFT: 5/200 20/400 15/200 20/200 20/100 20/70 20/50 20/40 or better

Second recording of corrected near vision:

RIGHT: 5/200 20/400 15/200 20/200 20/100 20/70 20/50 20/40 or better

LEFT: 5/200 20/400 15/200 20/200 20/100 20/70 20/50 20/40 or better

b. Explain reason for the difference between distance and near corrected vision

c. Does the lens required to correct distance vision in the poorer eye differ by more than 3 diopters from the lens required to correct distance vision in the better eye?

Yes No (If "Yes," explain reason for the difference)

3. PUPILS

a. Pupil diameter: Right: _____ mm Left: _____ mm

b. Pupils are round and reactive to light? Yes No

c. Is an afferent papillar defect present? Yes No

(If "Yes," indicate eye(s)) Right Left Both

d. Other, describe: _____

Eyes affected Right Left Both

4. ANATOMICAL LOSS, LIGHT PERCEPTION ONLY, EXTREMELY POOR VISION OR BLINDNESS

Does the veteran have anatomical loss, light perception only, extremely poor vision or blindness of either eye?

Yes No (If "Yes," complete Items 4A thru 4E)

a. Does the veteran have anatomical loss of either eye? Yes No

If "Yes," indicate for which eye Right Left Both

If "Yes," is veteran able to wear an ocular prosthesis Yes No

If "No," provide reason _____

b. Is the veteran's vision limited to no more than light perception only in either eye? Yes No

If "Yes," indicate for which eye(s) the veteran's vision is limited to no more than light perception Right Left Both

c. Is the veteran able to recognize test letters at 1 foot or closer? Yes No

If "No," indicate with which eye(s) the veteran is unable to recognize test letters at 1 foot or closer Right Left Both

d. Is the veteran able to perceive objects, hand movements, or count fingers at 3 feet? Yes No

If "No," indicate with which eye(s) the veteran is unable to perceive objects, hand movements, or count fingers at 3 feet: Right Left Both

e. Does the veteran have visual acuity of 20/200 or less in the better eye with use of a correcting lens based upon visual acuity loss (i.e. USA statutory blindness with bilateral visual acuity of 20/200 or less)?

Yes No

5. ASTIGMATISM

Does the veteran have a corneal irregularity that results in severe irregular astigmatism? Yes No

(If "Yes," complete Items 5A and 5B)

a. Does the veteran customarily wear contact lenses to correct for the above corneal irregularity? Yes No

If "Yes," does using contact lenses result in more visual improvement than using the standard spectacle correction? Yes No

b. Was the corrected visual acuity determined using contact lenses? Yes No

If "No," explain: _____

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SECTION III - PHYSICAL EXAMINATION (Continued)

6. DIPLOPIA

Does the veteran have diplopia (*double vision*)? Yes No

a. Provide etiology (*such as traumatic injury, thyroid eye disease, myasthenia gravis, etc.*):

b. The areas of diplopia must be documented on a Goldmann perimeter chart that identifies the four major quadrants (*upward, downward, left lateral and right lateral*) and the central field (*20 degrees or less*). Include the chart with this questionnaire.

Report the results from the Goldmann perimeter chart below.

Indicate the areas where diplopia is present (*the fields in which the veteran sees double using binocular vision*)

<input type="checkbox"/> Central 20 degrees	<input type="checkbox"/> 21 to 30 degrees	<input type="checkbox"/> 31 to 40 degrees	<input type="checkbox"/> Greater than 40 degrees
	<input type="checkbox"/> Down	<input type="checkbox"/> Down	<input type="checkbox"/> Down
	<input type="checkbox"/> Lateral	<input type="checkbox"/> Lateral	<input type="checkbox"/> Lateral
	<input type="checkbox"/> Up	<input type="checkbox"/> Up	<input type="checkbox"/> Up

c. Indicate frequency of the diplopia: Constant Occasional

If occasional, indicate frequency of diplopia and most recent occurrence: _____

d. Is the diplopia correctable with standard spectacle correction? Yes No (*If "No," complete Item 6E*)

e. Is the diplopia correctable with standard spectacle correction that includes a special prismatic correction? Yes No

7. TONOMETRY

a. If tonometry was performed, provide results:

Right eye pressure: _____ Left eye pressure: _____

b. Tonometry method used:

Goldmann applanation
 Other (*Describe*): _____

8. SLIT LAMP AND EXTERNAL EYE EXAM

a. External exam/lids/lashes:

Right: Normal Other (*Describe*): _____
 Left: Normal Other (*Describe*): _____

b. Conjunctiva:

Right: Normal Other (*Describe*): _____
 Left: Normal Other (*Describe*): _____

c. Cornea:

Right: Normal Other (*Describe*): _____
 Left: Normal Other (*Describe*): _____

d. Anterior chamber:

Right: Normal Other (*Describe*): _____
 Left: Normal Other (*Describe*): _____

e. Iris:

Right: Normal Other (*Describe*): _____
 Left: Normal Other (*Describe*): _____

f. Lens:

Right: Normal Other (*Describe*): _____
 Left: Normal Other (*Describe*): _____

9. INTERNAL EYE EXAM (FUNDUS)

Fundus:

Normal bilaterally Abnormal (*If Abnormal, complete Items 9A thru 9E*)

a. Optic disc:

Right: Normal Other (*Describe*): _____
 Left: Normal Other (*Describe*): _____

b. Macula:

Right: Normal Other (*Describe*): _____
 Left: Normal Other (*Describe*): _____

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SECTION III - PHYSICAL EXAMINATION (Continued)

9. INTERNAL EYE EXAM (Continued)

c. Vessels

Right: Normal Other (Describe): _____
 Left: Normal Other (Describe): _____

d. Vitreous

Right: Normal Other (Describe): _____
 Left: Normal Other (Describe): _____

e. Periphery

Right: Normal Other (Describe): _____
 Left: Normal Other (Describe): _____

10. VISUAL FIELDS

Does the veteran have a visual field defect (or a condition that may result in a visual field defect)?

Yes No (If "Yes," complete Items 10A thru 10E)

NOTE: For VA purposes, examiners must perform visual field testing using either Goldmann kinetic perimetry or automated perimetry using Humphrey Model 750, Octopus Model 101, or later versions of these perimetric devices with simulated kinetic Goldmann testing capability. The results must be recorded on a standard Goldmann chart providing at least 16 meridians 22½-degrees apart for each eye and **included with this questionnaire**.

If additional testing is necessary to evaluate visual fields, it must be conducted using either a tangent screen or a 30-degree threshold visual field with the Goldmann III stimulus size. The examination report must then include the tracing of either the tangent screen or of the 30-degree threshold visual field with the Goldmann III stimulus size.

a. Was visual field testing performed? Yes No

Results Using Goldmann's equivalent III/4e target
 Using Goldmann's equivalent IV/4e target (used for aphakic individuals not well adapted to contact lens correction or pseudophakic individuals not well adapted to intraocular lens implant)
 Other (Describe): _____

b. Does the veteran have loss of a visual field? Yes No

c. Does the veteran have loss of a visual field? Yes No (If "Yes," check all that apply and indicate eye affected):

- | | | | |
|----------------------------------------------------------------|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Homonymous hemianopsia | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Loss of temporal half of visual field | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Loss of nasal half of visual field | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Loss of inferior half of visual field | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Loss of superior half of visual field | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other (Specify): _____ | | | |

d. Does the veteran have a scotoma? Yes No (If "Yes," check all that apply and indicate eye affected):

- | | | | |
|-----------------------------------------------------------------------------|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Scotoma affecting at least 1/4 of the visual field | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Centrally located scotoma | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

e. Does the veteran have legal (statutory) blindness (visual field diameter of 20 degrees or less in the better eye, even if the corrected visual acuity is 20/20) based upon visual field loss?

Yes No

SECTION IV - EYE CONDITIONS

1. CONDITIONS

Does the veteran have any of the following eye conditions? Yes No (If "No," proceed to Section V) (If "Yes," check all that apply)

- Anatomical loss of eyelids and/or brows (If checked, complete Item 2 below)
- Lacrimal gland and lid disorders (other than ptosis or anatomic loss) (If checked, complete Item 3 below)
- Ptosis, for either or both eyelids (If checked, complete Item 4 below)
- Conjunctivitis and other conjunctival conditions (If checked, complete Item 5 below)
- Corneal conditions (If checked, complete Item 6 below)
- Inflammatory eye conditions and/or injuries (If checked, complete Item 8 below)
- Glaucoma (If checked, complete Item 9 below)
- Cataracts and lens conditions (If checked, complete Item 10 below)
- Retinal conditions (If checked, complete Item 11 below)
- Neurologic eye conditions (If checked, complete Item 12 below)
- Tumors and Neoplasms (If checked, complete Item 13 below)
- Other eye condition(s) (If checked, complete Item 14 below)

For each checked answer, complete the appropriate item (items 2 thru 14)

- -

SECTION IV - EYE CONDITIONS (Continued)

2. ANATOMICAL LOSS OF EYELIDS, BROWS, LASHES

a. Indicate the condition and side affected (Check all that apply)

- | | | | |
|-------------------------------------------------------------|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Partial or complete loss of eyelid | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Complete loss of eyebrows | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Complete loss of eyelashes | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

b. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to eyelid loss?

- Yes No There is no decrease in visual acuity or other visual impairment

If "No," explain: _____

c. If present, does eyelid loss cause scarring or disfigurement? Yes No (If "Yes," complete Section V, Scarring and Disfigurement)

3. LACRIMAL GLAND AND LIP CONDITIONS

a. Indicate the veteran's condition(s) and side affected (Check all that apply):

- | | | | | |
|-----------------------------------------------------------------------------------------------|----------------|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Ectropion | Side affected: | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Entropion | Side affected: | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Lagophthalmos | Side affected: | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Disorders of the lacrimal apparatus (epiphora, dacryocystitis, etc.) | | | | |

If checked, specify condition: _____

Side affected: Right Left Both

b. If present, does lacrimal or lid condition cause scarring or disfigurement? Yes No (If "Yes," complete Section V, Scarring and Disfigurement)

4. PTOSIS

a. If ptosis is present, indicate side affected: Right Left Both

b. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to ptosis?

- Yes No There is no decrease in visual acuity or other visual impairment

If "No," explain: _____

c. Does the Ptosis loss cause disfigurement? Yes No (If "Yes," complete Section V, Scarring and Disfigurement)

5. CONJUNCTIVITIS AND OTHER CONJUNCTIVAL CONDITIONS

a. Indicate type of conjunctivitis, activity, and side affected (check all that apply):

- | | | | |
|---------------------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Trachomatous | | <input type="checkbox"/> Nontrachomatous | |
| <input type="checkbox"/> Active | Eye affected: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Active | Eye affected: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Inactive | Eye affected: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Inactive | Eye affected: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |

b. Indicate the veteran's other conjunctival conditions, if any (Check all that apply):

- | | |
|-------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Pinguecula | Eye affected: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Symblepharon | Eye affected: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, describe: _____ | |

Eye affected: Right Left Both

c. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the eye conditions checked above in this section?

- Yes No There is no decrease in visual acuity or other visual impairment

If "No," explain: _____

d. Does any eye condition in this section cause scarring or disfigurement? Yes No (If "Yes," complete Section V, Scarring and Disfigurement)

6. CORNEAL CONDITIONS

a. Has the veteran had a corneal transplant? Yes No

If "Yes," indicate side of transplant: Right Left Both

Indicate residuals (Check all that apply):

- | | |
|---------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Pain | Eye affected: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Photophobia | Eye affected: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Glare sensitivity | Eye affected: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, (Describe): _____ | |

Eye affected: Right Left Both

b. Does the veteran have keratoconus? Yes No

If "Yes," indicate eye affected Right Left Both

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SECTION IV - EYE CONDITIONS (Continued)

6. CORNEAL CONDITIONS (Continued)

c. Does the veteran have pterygium? Yes No

If "Yes," indicate eye affected Right Left Both

d. Does the veteran have another corneal condition that may result in an irregular cornea? (For example, pellucid marginal degeneration, irregular astigmatism from corneal scar, post-laser refractive surgery, acne rosacea keratopathy, etc.)

Yes No

If "Yes," specify corneal condition _____

Eye affected: Right Left Both

e. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to keratoconus or another corneal condition, if present?

Yes No There is no decrease in visual acuity or other visual impairment

If "Yes," specify corneal condition responsible for visual impairment _____

If "No," explain: _____

f. Does any eye condition identified in this section cause scarring or disfigurement? Yes No (If "Yes," complete Section V, Scarring and Disfigurement)

7. CATARACT AND OTHER LENS CONDITIONS

a. Indicate cataract condition:

Preoperative (cataract is present) Eye affected: Right Left Both

Postoperative (cataract has been removed) Eye affected: Right Left Both

Is there aphakia or dislocation of the crystalline lens? Yes No

If "Yes," indicate eye Right Left Both

b. Is there a replacement intraocular lens? Yes No

If "Yes," indicate eye Right Left Both

c. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the eye conditions checked above in this section?

Yes No There is no decrease in visual acuity or other visual impairment

If "Yes," specify corneal condition responsible for visual impairment _____

If "No," explain _____

8. INFLAMMATORY EYE CONDITIONS AND/OR INJURIES

a. Indicate the veteran's condition and eye affected:

Choroidopathy (including uveitis, iritis, cyclitis, and choroiditis) Right Left Both

Keratopathy Right Left Both

Scleritis Right Left Both

Intraocular hemorrhage Right Left Both

Unhealed eye injury Right Left Both

Other, (Describe): _____

b. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any eye condition and/or injury checked above in this section?

Yes No There is no decrease in visual acuity or other visual impairment

If "Yes," specify inflammatory or traumatic condition responsible for visual impairment _____

If "No," explain _____

c. Does any eye condition identified in this section cause scarring or disfigurement? Yes No (If "Yes," complete Section V, Scarring and Disfigurement)

9. GLAUCOMA

a. Specify the type of glaucoma:

Angle-closure Eye affected: Right Left Both

Open-angle Eye affected: Right Left Both

Other, specify type (For example, neovascular, phakolytic, etc.): _____

Eye affected: Right Left Both

b. Does the glaucoma require continuous medication for treatment? Yes No

If "Yes," indicate side affected Right Left Both

List medication(s) used for treatment of glaucoma: _____

c. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to glaucoma?

Yes No There is no decrease in visual acuity or other visual impairment

If "No," explain: _____

d. Does any eye glaucoma condition identified in this section cause scarring or disfigurement? Yes No (If "Yes," complete Section V, Scarring and Disfigurement)

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SECTION IV - EYE CONDITIONS (Continued)

10. OPTIC NEUROPATHY AND OTHER DISC CONDITIONS

a. Indicate the optic neuropathy and other disc conditions, and eye affected (*check all that apply*):

- | | | | |
|-------------------------------------------------------|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Drusen of optic disc | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Ischemic optic neuropathy | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Nutritional optic neuropathy | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Optic atrophy | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other, (<i>Describe</i>): | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

b. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the eye conditions checked in Item 10A?

- Yes No There is no decrease in visual acuity or other visual impairment

If "Yes," specify optic neuropathy or disc condition responsible for visual impairment _____

If "No," explain _____

11. RETINAL CONDITIONS

a. Indicate retinal condition and eye affected (*check all that apply*):

- | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Retinopathy | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Maculopathy | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Detached retina | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Retinal hemorrhage | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Centrally located retinal scars, atrophy or irregularities in either eye that result in irregular, duplicated, enlarged or diminished image in either eye | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

b. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the eye conditions checked in Item 11A?

- Yes No There is no decrease in visual acuity or other visual impairment

If "Yes," specify retinal condition responsible for visual impairment _____

If "No," explain _____

12. NEUROLOGIC EYE CONDITIONS

a. Indicate the veteran's neurologic eye condition/disorder:

- Nystagmus
If checked, is nystagmus etiology central? Yes No
- Paresis/paralysis of 3rd cranial nerve (*oculomotor*) Eye affected: Right Left Both
- Paresis/paralysis of 4th cranial nerve (*trochlear*) Eye affected: Right Left Both
- Paresis/paralysis of 6th cranial nerve (*abducens*) Eye affected: Right Left Both
- Paresis/paralysis of 7th cranial nerve (*facial, Bell's palsy*) Eye affected: Right Left Both
- Eye condition due to cerebrovascular accident (*CVA*) Eye affected: Right Left Both
If checked, specify eye condition attributable to CVA: _____
- Eye condition due to demyelinating disease Eye affected: Right Left Both
If checked, specify eye condition attributable to demyelinating disease: _____
- Optic neuritis Eye affected: Right Left Both
- Eye condition due to intracranial mass/tumor Eye affected: Right Left Both
If checked, specify eye condition attributable to intracranial mass/tumor: _____
- Eye condition due to traumatic brain injury (*TBI*) Eye affected: Right Left Both
If checked, specify eye condition attributable to TBI: _____
- Other If checked, specify neurologic eye condition/disorder and name the underlying neurologic condition (*for example, Alzheimer's disease, Jakob-Creutzfeldt disease, etc.*)

- Eye affected: Right Left Both

b. Is the veteran's decrease in visual acuity or other visual impairment, if present, attributable to any of the neurologic eye conditions checked above in this section?

- Yes No There is no decrease in visual acuity or other visual impairment

If "Yes," specify condition responsible for visual impairment: _____

If "No," explain: _____

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SECTION IV - EYE CONDITIONS (Continued)

13. TUMORS AND NEOPLASMS

Does the veteran have a benign or malignant neoplasm or metastases related to any of the diagnosis listed in Section 1, Diagnosis? Yes No

(If "Yes," complete Items 13A thru 13E):

a. Is the neoplasm: Benign Malignant

b. Has the veteran completed treatment or is the veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?

Yes No, watchful waiting

If "Yes," indicate type of treatment the veteran is currently undergoing or has completed *(Check all that apply)*:

Treatment completed; currently in watchful waiting status

Surgery If checked, describe: _____
Date(s) of surgery: _____

Radiation therapy
Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

Antineoplastic chemotherapy
Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

Other therapeutic procedure
If checked, describe procedure: _____
Date of most recent procedure: _____

Other therapeutic treatment
If checked, describe treatment: _____
Date of completion of treatment or anticipated date of completion: _____

c. Does the veteran currently have any residual conditions or complications due to the neoplasm *(including metastases)* or its treatment, other than those already documented in the report in Item 13B?

Yes No

If "Yes," list residual conditions and complication *(Brief summary)*:

d. If there are additional benign or malignant neoplasms or metastases related to any of the diagnosis in Section I, Diagnosis, describe using the format in Item 13B:

e. Do any benign or malignant neoplasms or metastases identified in this section cause scarring or disfigurement? Yes No

(If "Yes," complete Section V, Scarring and Disfigurement)

14. OTHER EYE CONDITIONS, PERTINENT PHYSICAL FINDINGS, COMPLICATION, CONDITIONS, SIGNS AND/OR SYMPTOMS

a. Does the veteran have any other eye conditions, pertinent physical findings, complications, signs, and/or related to the condition at hand? Yes No

If "Yes," describe:

--	--	--	--	--	--	--	--	--	--	--	--

SECTION V - SCARRING AND DISFIGUREMENT

5. DOES THE VETERAN HAVE SCARRING OR DISFIGUREMENT ATTRIBUTABLE TO ANY EYE CONDITION?

Yes No

IF YES, INDICATE SCAR ATTRIBUTES (*check all that apply*):

- Scar at least one-quarter inch (*0.6cm*) wide at widest part
- Surface contour of scar elevated or depressed on palpation (*or inspection in the case of sclera*)
- Scar adherent to underlying tissue (*including eyelids adherent to scleral tissue*)
- Visible or palpable tissue loss
- Gross distortion or asymmetry of one feature or paired set of features (*eyes*)

NOTE: If possible, include color photographs with any report of scarring or disfigurement.

SECTION VI - INCAPACITATING EPISODES

NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician or other healthcare provider (*For example, temporary bed rest required for a retinal condition*).

6A. DURING THE PAST 12 MONTHS, HAS THE VETERAN HAD ANY INCAPACITATING EPISODES ATTRIBUTABLE TO ANY EYE CONDITION?

Yes No

If "Yes," specify the eye condition(s) causing incapacitating episodes: _____

6B. DESCRIBE HOW THE EYE CONDITION(S) CAUSED INCAPACITATING EPISODES:

6C. PROVIDE THE TOTAL DURATION FOR THE INCAPACITATING EPISODES FOR ALL INCAPACITATING CONDITIONS OVER THE PAST 12 MONTHS:

- Less than 1 week
- At least 1 week but less than 2 weeks
- At least 2 weeks but less than 4 weeks
- At least 4 weeks but less than 6 weeks
- At least six weeks

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SECTION VII - FUNCTIONAL IMPACT

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

Yes No

If "Yes," describe the impact of each of the veteran's eye condition(s), providing one or more examples:

SECTION VIII - REMARKS

8. REMARKS *(If any)*

SECTION IX - OPTOMETRIST/PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9A. OPTOMETRIST/PHYSICIAN'S SIGNATURE <i>(Sign in ink)</i>	9B. OPTOMETRIST/PHYSICIAN'S PRINTED NAME	9C. DATE SIGNED
9D. OPTOMETRIST/PHYSICIAN'S PHONE/FAX NUMBER	9E. OPTOMETRIST/PHYSICIAN'S NATIONAL PROVIDER IDENTIFIER (NPI)	9F. OPTOMETRIST/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 45 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.