OMB Control No. 2900-0776
Respondent Burden: 15 minutes

Department of Veterans Affairs

TEMPOROMANDIBULAR JOINT (TMJ) CONDITIONS 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 A TEMPOROMANDIBULAR JOINT CONDITION?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO TEMPOROMANDIBULAR (TMJ) JOINT CONDITIONS:

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1C. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO TEMPOROMANDIBULAR (TMJ) CONDITIONS, LIST USING ABOVE FORMAT

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE CAUSE/ONSET OF THE VETERAN'S TEMPOROMANDIBULAR JOINT CONDITION

2B. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE TEMPOROMANDIBULAR JOINT?

☐ YES ☐ NO *(If "Yes," document the veteran's description of the impact of flare-ups on function in his or her own words)*

SECTION III - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS

NOTE - Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use testing must be included in all exams. The VA has determined that 3 repetitions of ROM can serve as a representative test of the effect of repetitive use. After the initial measurements, reassess ROM after 3 repetitions. Report post-test measurements in section 4.

3A. INITIAL RANGE OF MOTION FOR LATERAL EXCURSION

- ☐ 0 to 4 mm
- ☐ Greater than 4 mm

3B. INITIAL RANGE OF MOTION FOR OPENING MOUTH, MEASURED BY INTER-INCISAL DISTANCE

- ☐ Greater than 40 mm
- ☐ 31 to 40 mm
- ☐ 21 to 30 mm
- ☐ 11 to 20 mm
- ☐ 0 to 10 mm

3C. IF ROM DOES NOT CONFORM TO THE NORMAL RANGE OF MOTION IDENTIFIED ABOVE BUT IS NORMAL FOR THIS VETERAN *(For reasons other than a temporomandibular joint condition, such as age, body habitus, neurologic disease)*, EXPLAIN:

SECTION IV - ROM MEASUREMENT AFTER REPETITIVE USE TESTING

4A. DOES THE VETERAN HAVE ANY ADDITIONAL LIMITATION IN ROM FOLLOWING REPETITIVE USE TESTING?

☐ YES ☐ NO

(If "No," skip to section 5)

(If "Yes," provide post-test measurements _____ *)*

(If veteran is unable to perform 3 repetitions, explain _____ *)*

4B. POST-TEST RANGE OF MOTION FOR LATERAL EXCURSION

☐ 0 to 4 mm

☐ Greater than 4 mm

4C. POST-TEST RANGE OF MOTION FOR OPENING MOUTH, MEASURED BY INTER-INCISAL DISTANCE

☐ Greater than 40 mm

☐ 31 to 40 mm

☐ 21 to 30 mm

☐ 11 to 20 mm

☐ 0 to 10 mm

SECTION V - FUNCTIONAL LOSS

NOTE - The following section addresses reasons for functional loss, if present, and additional loss of ROM after repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working movements of the body with normal excursion, strength, coordination and/or endurance.

5. REASONS FOR FUNCTIONAL LOSS *(Check all that apply)*

☐ NONE, NO ADDITIONAL LIMITATION OF MOVEMENT AFTER REPETITIVE USE TESTING

☐ LESS MOVEMENT THAN NORMAL

☐ MORE MOVEMENT THAN NORMAL

☐ WEAKENED MOVEMENT

☐ EXCESS FATIGABILITY

☐ INCOORDINATION, IMPAIRED ABILITY TO EXECUTE SKILLED MOVEMENTS SMOOTHLY

☐ PAIN ON MOVEMENT

☐ SWELLING

☐ DEFORMITY

☐ ATROPHY OF DISUSE

SECTION VI - FUNCTIONAL IMPACT AND REMARKS

6. DOES THE VETERAN'S TEMPOROMANDIBULAR JOINT CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact, providing one or more examples)*

7. REMARKS *(If any)*

SECTION VII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

8A. PHYSICIAN'S SIGNATURE	8B. PHYSICIAN'S PRINTED NAME	8C. DATE SIGNED

8D. PHYSICIAN'S PHONE NUMBER	8E. PHYSICIAN'S MEDICAL LICENSE NUMBER	8F. 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 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.