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General Medical Examination

Name:	SSN:
Date of Exam:	C-number:
Place of Exam:	

Narrative: This is a comprehensive base-line or screening examination for all body systems, not just specific conditions claimed by the veteran. It is often the initial post-discharge examination of a veteran requested by the Compensation and Pension Service for disability compensation purposes. As a screening examination, it is not meant to elicit the detailed information about specific conditions that is necessary for rating purposes. **Therefore, all claimed conditions, and any found or suspected conditions that were not claimed, should be addressed by referring to and following all appropriate worksheets, in addition to this one, to assure that the examination for each condition provides information adequate for rating purposes**. This does not require that a medical specialist conduct examinations based on other worksheets, except in the case of vision and hearing problems, mental disorders, or especially complex or unusual problems. **Vision, hearing, and mental disorder examinations must be conducted by a specialist**.

The examiner may request any additional studies or examinations needed for proper diagnosis and evaluation (see other worksheets for guidance). All important negatives should be reported. The regional office may also request a general medical examination as evidence for nonservice-connected disability pension claims or for claimed entitlement to individual unemployability benefits in service-connected disability compensation claims. Barring unusual problems, examinations for pension should generally be adequate if only this general worksheet is followed.

A. Review of Medical Records: Indicate whether the C-file was reviewed.

B. Medical History (Subjective Complaints):

1. Discuss: Whether an injury or disease that is found occurred during active service, before active service, or after active service. To the extent possible, describe the circumstances, dates, specific injury or disease that occurred, treatment, follow-up, and residuals. If the injury or disease occurred before active service, describe any worsening of residuals due to being in military service. Describe current symptoms,
2. If there are flareups of any joint (including of spine, hands, and feet) or muscle disease, state the frequency, duration, precipitating factors, alleviating factors, and the extent, if any, per veteran, they result in additional limitation of motion or other functional impairment during the flareup.
3. Describe details of current treatment, conditions being treated, and side effects of treatment.

4. Describe all surgery and hospitalizations in and after service with approximate

dates.

5. If a neoplasm is or was present, state whether benign or malignant and provide:
   a. Exact diagnosis and date of confirmed diagnosis.
   b. Location of neoplasm
   c. Types and dates of treatment
   d. For malignant neoplasm, also state exact date of the last surgical, X-ray, antineoplastic chemotherapy, radiation, or other therapeutic procedure.
   e. If treatment is already completed, provide date of last treatment and fully describe residuals. If not completed, state expected date of completion.

C. Physical Examination (Objective Findings):

Address each of the following and fully describe current findings: The examiner should incorporate results of all ancillary studies into the final diagnoses.

1. **VS:** Heart rate, blood pressure (see #13 below), respirations, height, weight, maximum weight in past year, weight change in past year, body build, and state of nutrition.

2. **Dominant hand:** Indicate the dominant hand and how this was determined, e.g., writes, eats, combs hair with that hand.

3. **Posture and gait:** Describe abnormality and reason for it. Describe any ambulatory aids and name the condition requiring the ambulatory aid(s).

4. **Skin, including appendages:** If abnormal, describe appearance, location, extent of lesions. If there are laceration or burn scars, describe the location, exact measurements (cm. x cm.), shape, depression, type of tissue loss, adherence, and tenderness. See the Scars worksheet for further guidance. Describe any limitation of activity or limitation of motion due to scarring or other skin lesions. **NOTE:** If there are disfiguring scars (of face, head, or neck), obtain color photographs of the affected area(s) to submit with the examination report.

5. **Hemic and Lymphatic:** Describe adenopathy, tenderness, suppuration, edema, pallor, etc.

6. **Head and face:** Describe scars, skin lesions, deformities, etc., as discussed under Skin.

7. **Eyes:** Describe external eye, pupil reaction, eye movements. State corrected visual acuity and gross visual field assessment.

8. **Ears:** Describe canals, drums, perforations, discharge. State whether hearing is grossly normal or abnormal. Is there a current complaint of tinnitus? If so, do you believe it is related to a current medical or psychological

problem, or is the etiology unknown without further information?

9. **Nose, sinuses, mouth and throat:** Include gross dental findings. For sinusitis, describe headaches, pain, incapacitating (meaning an episode of sinusitis that requires bed rest and treatment by a physician with 4-6 weeks of antibiotic treatment), and non-incapacitating episodes of sinusitis during the past 12-month period frequency and duration of antibiotic treatment.

10. **Neck:** Describe lymph nodes, thyroid, etc.

11. **Chest:** Inspection, palpation, percussion, auscultation. Describe respiratory symptoms and effect on daily activities, e.g., how far the veteran can walk, how many flights of stairs veterans can climb. If a respiratory condition is claimed or suspected, refer to appropriate worksheet(s). Most respiratory conditions will require PFT's, including post-bronchodilation studies.

12. **Breast:** Describe masses, scars, nipple discharge, skin abnormalities. Give date of last mammogram, if any. Describe any breast surgery (with approximate date) and residuals.

13. **Cardiovascular:** NOTE: If there is evidence of a cardiovascular disease, or one is claimed, refer to appropriate worksheet(s).

    a. Record pulse, quality of heart sounds, abnormal heart sounds, arrhythmias. Describe symptoms and treatment for any cardiovascular condition, including peripheral arterial and venous disease. Give NYHA classification of heart disease. A determination of METs by exercise testing may be required for certain cardiovascular conditions, and an estimation of METS may be required if exercise testing cannot be conducted for medical reasons. Report heart size and how determined. (See the cardiovascular worksheets for further guidance.)
    b. Describe the status of peripheral vessels and pulses. Describe edema, stasis pigmentation or eczema, ulcers, or other skin or nail abnormalities. Describe varicose veins, including extent to which any resulting edema is relieved by elevation of extremity. Examine for evidence of residuals of cold injury when indicated. See and follow special cold injury examination worksheet if there is a history of cold exposure in service and the special cold injury examination has not been previously done.
    c. **Blood Pressure:** (Per the rating schedule, hypertension means that the diastolic blood pressure is predominantly 90mm. or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm. or greater with a diastolic blood pressure of less than 90mm.)

        i. If the diagnosis of hypertension has not been previously established, and it is a claimed issue, B.P. readings must be taken two or more times on each of at least three different days.
        ii. If hypertension has been previously diagnosed and is claimed, but the

claimant is not on treatment, B.P. readings must be taken two or more times on at least three different days.

iii. If hypertension has been previously diagnosed, and the claimant is on treatment, take three blood pressure readings on the day of the examination.

iv. If hypertension has not been claimed, take three blood pressure readings on the day of the examination. If they are suggestive of hypertension or are borderline, readings must be taken two or more times on at least two additional days to rule hypertension in or out.

v. In the diagnostic summary, state whether hypertension is ruled in or out after completing these B.P. measurements. If hypertensive heart disease is suspected or found, follow worksheet for Heart.

14. **Abdomen:** Inspection, auscultation, palpation, percussion. Describe any organ enlargement, ventral hernia, mass, tenderness, etc.

15. **Genital/rectal (male):** Inspection and palpation of penis, testicles, epididymis, and spermatic cord. If there is a hernia, describe type, location, size, whether complete, reducible, recurrent, supported by truss or belt, and whether or not operable. Describe anal fissures, hemorrhoids, ulcerations, etc. Include digital exam of rectal walls and prostate.

16. **Genital/rectal (female):** Pelvic exam, including inspection of introitus, vagina, and cervix, palpation of labia, vagina, cervix, uterus, adnexa, and ovaries, rectal exam. Do Pap smear if none within past year. If unable to conduct an examination and Pap smear, or if there is a severe or complex problem, refer to a specialist.

17. **Musculoskeletal:**

    a. For all joint or muscle disorders, state each muscle and joint affected.
    b. Separately examine and describe in detail each affected joint. Measure active range of motion in degrees using a goniometer. State whether there is objective evidence of pain on motion. After 3 repetitions of the range of motion, state whether there are additional limitations of range of motion and whether there is objective evidence of pain on motion. Also state the most important factor (pain, weakness, fatigue, lack of endurance, incoordination) for any additional loss of motion after repetitive motion. Report the range of motion after 3 repetitions. (See the appropriate musculoskeletal worksheet for more details.)
    c. Describe swelling, effusion, tenderness, muscle spasm, joint laxity, muscle atrophy, fibrous or bony residual of fracture. If joint is ankylosed, describe the position and angle of fixation.
    d. If foot problems exist, also describe objective evidence of pain at rest and on manipulation, rigidity, spasm, circulatory disturbance, swelling, callus, loss of strength, and whether condition is acquired or congenital.
    e. If there is amputation of a part, see the appropriate worksheet.

f. With disc disease, also describe any abnormal neurological findings and total duration in days or weeks of incapacitating episodes (an incapacitating episode is a period of acute signs and symptoms due to intervertebral disc syndrome that requires bed rest prescribed by a physician and treatment by a physician).

18. **Endocrine:** Describe signs and symptoms of any endocrine disease, effects on other body systems. See endocrine worksheets for further guidance.

19. **Neurological:** Assess orientation and memory, gait, stance, and coordination, cranial nerve functions. Assess deep tendon reflexes, pain, touch, temperature, vibration, and position, motor and sensory status of peripheral nerves. If neurological abnormalities are found on examination, or there is a history of seizures, refer to appropriate worksheet.

20. **Psychiatric:** Describe affect, mood, judgment, behavior, comprehension of commands, hallucinations or delusions, and intelligence (This is meant to be a brief screening examination. If a mental disorder is claimed, or suspected based on the screening, an examination for diagnosis and assessment should be conducted by a psychiatrist or psychologist.)

D. Diagnostic and Clinical Tests:

1. Include results of all diagnostic and clinical tests conducted in the examination report.
2. Review all test results before providing the summary and diagnosis.
3. Follow additional worksheets, as appropriate.
4. The diagnosis of degenerative or traumatic arthritis of any joint requires X-ray confirmation, but once confirmed by X-ray, either in service or after service, no further X-rays of that joint are required for disability evaluation purposes.

E. Diagnosis:

1. Provide a summary list of all disabilities diagnosed. Include an interpretation of the results of all diagnostic and other tests conducted in the final summary and diagnosis.
2. For each condition diagnosed, describe its effect on the veteran's usual occupation and daily activities.
3. **Capacity to Manage Financial Affairs:** Mental competency, for VA benefits purposes, refers only to the ability of the veteran to manage VA benefit payments in his or her own best interest, and not to any other subject. Mental incompetency, for VA benefits purposes, means that the veteran, because of injury or disease, is not capable of managing benefit payments in his or her best interest. In order to assist raters in making a legal determination as to competency, please address the following:

What is the impact of injury or disease on the veteran's ability to manage his or her financial affairs, including consideration of such things as knowing the amount of his or her VA benefit payment, knowing the amounts and types of bills owed monthly, and handling the payment prudently? Does the veteran handle the money and pay the bills himself or herself?

Based on your examination, do you believe that the veteran is capable of managing his or her financial affairs? Please provide examples to support your conclusion.

If you believe a Social Work Service assessment is needed before you can give your opinion on the veteran's ability to manage his or her financial affairs, please explain why.

Signature: Date: