

MEDICAL OPINION • EXAMPLE

Nexus Letter — Filled Example

EXAMPLE ONLY — NOT A REAL VETERAN OR PROVIDER.

The veteran, the provider and every detail below are fictional, written to show what a complete, reasoned medical opinion looks like on the page. A provider writes their own letter, in their own words, on their own letterhead. See **Nexus Letter Template** for the part-by-part guide.

This is the same fictional letter the template walks through, assembled as the provider would actually send it — so you can see the length and the proportions. Notice where the weight sits: the opinion is three sentences; the records, the history and the rationale are most of the page.

Ridgeline Family Medicine · 400 Market St., Clarksville, TN 37040 · (931) 555-0100

October 14, 2026

Re: Independent Medical Opinion — Marcus T. Webb, DOB 03/14/1991, SSN ending 0000. Question: whether the veteran's diagnosed migraine without aura is related to his active military service, directly or secondary to his service-connected post-traumatic stress disorder.

To the Department of Veterans Affairs:

Qualifications

I am a board-certified family nurse practitioner (DNP, FNP-BC), licensed in the State of Tennessee, license #0000000, in primary-care practice for eleven years. My practice includes the diagnosis and ongoing management of primary headache disorders, and I have treated veterans with post-traumatic headache since 2017.

Basis of this opinion

I examined Mr. Webb in person on October 2, 2026, for ninety minutes, and reviewed the following before writing this opinion: his DD-214; his complete service treatment records (2010-2016), which contain no visit for headache; his Post-Deployment Health Assessment dated November 2014, on which he checked "headaches" under symptoms experienced during deployment; his separation Report of Medical History (DD 2807-1) dated April 2016, on which he marked "frequent or severe headaches — yes"; VA primary-care notes 2017-2025; the VA rating decision of July 2024 granting service connection for PTSD at 50 percent; his signed personal statement dated September 3, 2026; a lay statement from SSG (ret.) D. Alvarez, who served in his platoon, dated September 10, 2026; and the VA examination report of August 12, 2026.

History

Mr. Webb reports that his headaches began during his second Afghanistan deployment in 2014, following months of demolition work and proximity to controlled detonations and at least two IED blasts within fifty meters. He describes unilateral throbbing pain with photophobia, phonophobia and nausea, initially two to three times a month, which he treated with over-the-counter ibuprofen and did not report at sick call because, in his words, “you didn’t go to sick call for a headache in my platoon.” Since 2020 the attacks have increased to four or five a month, of which roughly two are fully prostrating: he must stop work, lie in a dark room, and typically vomits, for three to six hours. He has missed or cut short an average of two work days a month over the past year. SSG Alvarez’s statement describes driving him to the aid station in 2014 on a day he could not see well enough to drive. I find this history credible and medically plausible: the onset after repeated blast exposure, the symptom pattern, the self-treatment and the gradual escalation are each typical of post-traumatic migraine, and the 2014 PDHA and 2016 separation history corroborate the timeline the veteran gives.

Examination and diagnosis

Neurological examination on October 2, 2026, was non-focal. Mr. Webb keeps a headache diary (June–September 2026, reviewed) documenting 18 attacks in 16 weeks, 8 of them prostrating. His presentation meets ICHD-3 criteria for migraine without aura (1.1), with a clinical course consistent with persistent post-traumatic headache attributed to mild traumatic injury to the head (ICHD-3 5.2.2). Diagnosis: migraine without aura, intractable, ICD-10 G43.019.

Opinion

It is my opinion that it is **at least as likely as not** (a 50 percent or greater probability) that Mr. Webb’s migraine without aura had its onset during his active military service and is etiologically related to his documented blast exposure as a combat engineer in Afghanistan in 2014.

In the alternative, it is my opinion that it is **at least as likely as not** that Mr. Webb’s migraine disorder is **proximately due to** his service-connected post-traumatic stress disorder; and, separately, that it is **at least as likely as not** that his migraine disorder has been **aggravated beyond its natural progression** by his service-connected PTSD. The baseline before aggravation, from his own account and the 2017–2019 VA notes, was two to three attacks a month, against four to five now.

Rationale

Headache is the most frequently reported symptom after blast-related mild traumatic brain injury, and the migraine phenotype predominates: in a cohort of U.S. soldiers returning from Iraq and Afghanistan with concussion, post-traumatic headache was present in the large majority and was most often migrainous in character (Theeler, Flynn & Erickson, Headache, 2010). Repetitive low-level blast exposure of the kind a combat engineer sustains during demolition work is an

established mechanism for this injury even in the absence of a single diagnosed concussion. Mr. Webb's history fits that mechanism precisely: onset during a deployment with repeated blast exposure, a migrainous symptom pattern from the start, and escalation over time, which is the natural history of persistent post-traumatic headache.

The absence of an in-service treatment note is not medically significant here. Under-reporting of headache in deployed infantry and engineer units is well documented, the veteran gives a credible reason for not reporting, and two contemporaneous documents — the November 2014 PDHA and the April 2016 separation history — record the complaint in his own hand.

On the secondary question: migraine and PTSD are strongly comorbid, with shared mechanisms in autonomic arousal, sleep disruption and central sensitization, and the literature supports both a causal contribution and a worsening effect of psychiatric comorbidity on migraine frequency. Mr. Webb's escalation from 2020 coincides with the period of worsening PTSD symptoms documented in his VA mental health notes and in the July 2024 rating decision.

I considered alternative etiologies. There is no family history of migraine, no medication-overuse pattern on the diary, no hypertension, and no new precipitant in the post-service record that would account for onset in 2014. A condition can have more than one service-related cause; the secondary opinion above does not weaken the direct one.

The VA examination of August 12, 2026

That report concludes the condition is "less likely than not related to service because service treatment records are silent for complaints, treatment or diagnosis of headaches." That reasoning does not address the November 2014 Post-Deployment Health Assessment or the April 2016 separation Report of Medical History, both of which record headache complaints during service, and it gives no consideration to the veteran's or the witness's account of onset. It rests entirely on the absence of a sick-call entry, which, for the reasons given above, is not medically probative in this case.

This opinion is my own, formed to a reasonable degree of medical certainty on the basis of the examination and records described above. I am available to clarify any part of it.

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Tennessee APRN license #0000000

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Signed October 14, 2026