

Compensation and Pension Record Interchange (CAPRI)

CAPRI Compensation and Pension Worksheet Module (CPWM)

Templates and AMIE Worksheet Disability Benefits Questionnaires (DBQs)

Release Notes

Patch: DVBA\*2.7\*169

August 2011

Department of Veterans Affairs

Office of Enterprise Development

Management & Financial Systems

**Preface**

**Purpose of the Release Notes**

The Release Notes document describes the new features and functionality of patch DVBA\*2.7\*169. (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs).

The information contained in this document is not intended to replace the CAPRI User Manual. The CAPRI User Manual should be used to obtain detailed information regarding specific functionality.

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# Purpose

The purpose of this document is to provide an overview of the enhancements specifically designed

for Patch DVBA\*2.7\*169.

# Overview

This patch introduces enhancements to the AUTOMATED MED INFO EXCHANGE (AMIE) V 2.7

package and the Compensation & Pension Record Interchange (CAPRI) application, Compensation & Pension Worksheet Module (CPWM) in support of modified Compensation and Pension (C&P)

Disability Benefit Questionnaires (DBQs).

* **DBQ HEARING LOSS AND TINNITUS**
* **DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA**
* **DBQ KIDNEY CONDITIONS (NEPHROLOGY)**
* **DBQ MALE REPRODUCTIVE SYSTEM CONDITIONS**
* **DBQ PROSTATE CANCER**
* **DBQ SKIN DISEASES**

This patch consists of template defects fixes. A word wrapping issue was identified in

the reporting of the following DBQs. There are no changes to the content required.

* **DBQ AMYOTROPHIC LATERIAL SCLEROSIS (LOU GEHRIG’S DISEASE)**
* **DBQ HAIRY CELL AND OTHER B-CELL LEUKEMIAS (formerly DBQ LEUKEMIA Template)**
* **DBQ ISCHEMIC HEART DISEASE**
* **DBQ PARKINSONS**

In addition to this patch VBAVACO has approved the renaming of CAPRI DBQ LEUKEMIA to

DBQ HAIRY CELL AND OTHER B-CELL LEUKEMIAS to avoid confusion with

DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA

questionnaire.

# Associated Remedy Tickets & New Service Requests

There are no Remedy tickets or New Service Requests associated with patch DVBA\*2.7\*169.

# Defects Fixes

There are defect fixes associated with patch DVBA\*2.7\*169. A word wrapping issue was reported

with CAPRI DBQ Templates reports and has been corrected in this patch.

# Enhancements

This section provides an overview of the modifications and primary functionality that will be

delivered in Patch DVBA\*2.7\*169.

## 5.1. CAPRI DBQ Template Modifications

Veterans Benefits Administration Veterans Affairs Central Office (VBAVACO) has approved

modifications for the following Disability Benefits Questionnaires:

* **DBQ HEARING LOSS AND TINNITUS**
* **DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA**
* **DBQ KIDNEY CONDITIONS (NEPHROLOGY)**
* **DBQ MALE REPRODUCTIVE SYSTEM CONDITIONS**
* **DBQ PROSTATE CANCER**
* **DBQ SKIN DISEASES**

VBAVACO has approved renaming the current "DBQ LEUKEMIA" CAPRI template to

"DBQ HAIRY CELL AND OTHER B-CELL LEUKEMIAS", to avoid potential confusion

with the "DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA"

template

This patch includes content changes to the following CAPRI DBQ templates listed below:

### 5.1.2. HEARING LOSS AND TINNITUS (changed from released version ~166)

**5.1.2.1. Section 1: HEARING LOSS, 1 Objective Findings, the Instructions, the second**

**sentence was changed to the following:**

**Old version:**

“Report the decibel value, which ranges from - 10 dB to 105 dB, for each of the frequencies.”

**New version:**

“Report the decibel (dB) value, which ranges from - 10 dB to 105 dB, for each of the frequencies.”

**5.1.2.2. Section 1: HEARING LOSS, 1 Objective Findings, part c has been changed to the following:**

**Old version:**

c. Validity of puretone test results:

Test results are valid.

Test results are invalid (not indicative of organic hearing loss).

**New version:**

c. Validity of puretone test results:

Test results are valid for rating purposes.

Test results are not valid for rating purposes (not indicative of organic hearing loss).

**5.1.2.3. Section 1: HEARING LOSS, 1 Objective Findings, part f, (Audiologic Findings)**

**A new selection both Right and Left Ear was added: “Unable to interpret reflexes due to artifact.”**

**5.1.2.4. Section 1: HEARING LOSS, 2 Diagnosis new selections both Right and Left Ear was added:“Conductive hearing loss” and “Mixed hearing loss.”**

**5.1.2.5. Section 2: TINNITUS, 3 Etiology of tinnitus was changed to the following:**

**Old version:**

a. Tinnitus associated with hearing loss

The Veteran has a diagnosis of hearing loss according to VA criteria, and his or her tinnitus is at least

as likely as not (50% probability or greater) a symptom associated with the hearing loss, as tinnitus is known

to be a symptom associated with hearing loss

The Veteran’s tinnitus is not likely a symptom associated with Veteran’s hearing loss, as Veteran does not

have hearing loss according to VA criteria

b. Tinnitus not associated with hearing loss

NOTE: Select answer below and provide rationale.

The Veteran’s tinnitus is:

At least as likely as not (50% probability or greater) caused by or a result of military noise exposure

Rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At least as likely as not (50% probability or greater) due to a known etiology (such as traumatic brain injury)

Etiology and rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Not caused by or a result of military noise exposure

Rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cannot provide a medical opinion regarding the etiology of the Veteran’s tinnitus without resorting to

speculation

Reason speculation required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New version:**

Select answer below and provide rationale where requested:

The Veteran has a diagnosis of clinical hearing loss, and his or her tinnitus is at least as likely as not (50% probability or greater) a symptom associated with the hearing loss, as tinnitus is known to be a symptom

associated with hearing loss

Less likely than not (less than 50% probability) a symptom associated with the Veterans hearing loss

Rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At least as likely as not (50% probability or greater) caused by or a result of military noise exposure

Rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At least as likely as not (50% probability or greater) due to a known etiology (such as traumatic brain injury)

Etiology and rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Less likely than not (less than 50% probability) caused by or a result of military noise exposure

Rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cannot provide a medical opinion regarding the etiology of the Veteran’s tinnitus without resorting to

speculation

Reason speculation required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### 5.1.3. HEMIC (Changed from released version ~166)

**5.1.3.1. Section 4 (Anemia and thrombocytopenia), part b, changed the following sentence:**

**Old version:**

“If the Veteran has thrombocytopenia, select the answer that best represents the Veteran’s condition:”

**New version:**

“If yes, check all that apply:”

### 5.1.4. KIDNEY CONDITONS (Changed from released version ~163)

**5.1.4.1.Section 1 (Diagnosis), the following question has been removed:**

“If no, provide rationale (e.g., Veteran has never had any known kidney condition(s)):”

**5.1.4.2. Section 1 (Diagnosis), Made the c in code lower case in all instances of "ICD code"**

**and the d in diagnosis lower case in all instances of "Date of diagnosis."**

**5.1.4.3. Section 1, the following selections have been added to the list of possible diagnoses:**

Cholesterol emboli ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_

Cystic kidney disease ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_

Congenital kidney disorder ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_

Other inherited kidney disorder, specify: ICD code: \_\_\_\_\_\_ Date of diagnosis:\_\_\_\_\_\_\_\_\_

**5.1.4.4 Section 2 (Medical history) was changed from:**

Describe the history (including cause, onset and course) of the Veteran’s kidney condition: \_\_\_\_\_\_\_

**Old version:**

* 1. Describe the history (including cause, onset and course) of the Veteran’s kidney condition (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New version:**

* 1. Does the Veteran’s treatment plan include taking continuous medication for the diagnosed condition?

Yes  No

List medications taken for the diagnosed condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5.1.4.5. Section 3 (Renal dysfunction), the top question is no longer designated part a and**

**the subsequent parts have been re-lettered. In addition the question was changed:**

**Old version:**

Does the Veteran have renal dysfunction?

Yes  No

**New version:**

Does the Veteran have renal dysfunction? (Evidence of renal dysfunction includes either persistent proteinuria, hematuria or GFR < 60 cc/min/1.73m2)

Yes  No

If yes, complete the following section:

**5.1.4.6. Section 3, part b, “Other, describe:” was added to the list of a signs/symptoms.**

**5.1.4.7. Section 4 (Urolithiasis) has been changed to the following:**

**Old version:**

c. Does the Veteran have kidney, ureteral or bladder calculi?

Yes  No

If yes, indicate location (check all that apply)

Kidney  Ureter  Bladder

If the Veteran has urolithiasis, complete the following:

**New version:**

Does the Veteran now have or has he/she ever had kidney, ureteral or bladder calculi (urolithiasis)?

Yes  No

If yes, complete the following section:

1. Indicate current/past location of calculi (check all that apply)

Kidney  Ureter  Bladder

**5.1.4.8. Section 5 (Urinary tract/kidney infection has been changed to the following:**

**Old version:**

Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?

Yes  No

If yes, provide etiology: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the Veteran has had recurrent symptomatic urinary tract or kidney infections, indicate all treatment modalities that apply:

**New version:**

Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?

Yes  No

If yes, complete the following section:

* 1. Etiology of recurrent urinary tract or kidney infections: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  2. Indicate all treatment modalities used for recurrent urinary tract or kidney infections (check all that apply):

**5.1.4.9. Section 6 (Kidney transplant or removal) has been changed to the following:**

**Old version:**

a. Has the Veteran had a kidney removed?

Yes  No

If yes, provide reason:

Kidney donation

Due to disease

Due to trauma or injury

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New version:**

Has the Veteran had a kidney transplant or removal?

Yes  No

If yes, complete the following section:

a. Has the Veteran had a kidney removed?

Yes  No

If yes, provide reason:

Kidney donation

Due to disease

Due to trauma or injury

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5.1.4.10. Section 6 part b question has been changed to the following:**

**Old version If Yes statement:**

“If yes, date of admission:”

**New version If yes statement:**

“If yes, date of transplant:”

**Old version Date questions statement:**

“Date of discharge:”

**New version questions statement:**

“Name of treatment facility, date of admission and date of discharge for transplant:”

**5.1.4.11. Section 7 (Tumors and neoplasms), part a, the sentence:“If yes, complete the**

**following:” has been changed:**

“If yes, complete the following section:”

**5.1.4.12. Section 9 (Diagnostic testing), an additional sentence has been added to the NOTE:**

“Provide testing completed appropriate to Veteran’s condition; testing indicated below is not indicated for every

kidney condition”

**5.1.4.13.Section 9, part c, the selection:“Protein (albumin):”has been changed to following:**

“Proteinuria (albumin):”

**5.1.4.14.Section 9, part d, was changed to following:**

**Old version:**

d. Urine microalbumin: Date: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New version:**

d. Spot urine microalbumin/creatinine: Date: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

### 5.1.5. MALE REPRODUCTIVE SYSTEM CONDITIONS (changed from released version ~163)

**5.1.5.1. Section 1 (Diagnosis), the following question has been removed:**

“If no, provide rationale (e.g., Veteran has never had any known male reproductive organ conditions):”

**5.1.5.2.Section 1 (Diagnosis), made the “c” in code lower case in all instances of "ICD code" and**

**the “d” in diagnosis lower case in all instances of "Date of diagnosis"**

**5.1.5.3. Section 2 (Medical History), part b, changed the following sentence:**

**Old version:**

“List medications:”

**New version:**

“List medications taken for the diagnosed condition:”

**5.1.5.4. A new question was added to section 3 (Voiding dysfunction):**

“a. Etiology of voiding dysfunction:”

**5.1.5.5.Section 4 (Urinary tract/kidney infection), the following question has been changed:**

**Old version:**

“If yes, provide etiology:”

**New version:**

“If yes, complete the following section:”

**5.1.5.6.Section 4, consist of a new question that was added:**

“a. Etiology of recurrent urinary tract or kidney infections:”

**5.1.5.7.Section 5 (Erectile dysfunction), the following question “If yes, provide etiology:” has**

**been changed to the following:**

“If yes, complete the following section:”

**5.1.5.8.Section 5 the following new question was added:**

“a. Etiology of erectile dysfunction:”

**5.1.5.9.Section 6 (Retrograde Ejaculation), the question:“If yes, provide etiology of the retrograde ejaculation:”has been replaced by the following sentence:**

“If yes, complete the following section:”

**5.1.5.19.Section 6, the following new question was added:**

“a. Etiology of retrograde ejaculation:”

**5.1.5.11. Section 7 (Male reproductive organ infections), the following sentence has been changed;**

**Old version:**

“If yes, indicate all treatment modalities that apply:”

**New version:**

“If yes, indicate all treatment modalities used for chronic epididymitis, epididymo-orchitis or prostatitis (check all that apply):”

**5.1.5.12.Section 8 (Physical exam), part a, the following selection has been changed:**

**Old version:**

“Not examined; penis exam not relevant to condition”

**New version:**

“Not examined per Veteran’s request; Veteran reports normal anatomy with no penile deformity or abnormality”

**5.1.5.13.Section 8 (Physical exam), part b, the following selection has been changed:**

**Old version:**

Not examined; testicular exam not relevant to condition”

**New version:**

“Not examined per Veteran’s request; Veteran reports normal anatomy with no testicular deformity or abnormality”

**5.1.5.14. Section 8 (Physical exam), part c, the following selection has been changed:**

**Old version:**

“Not examined; epididymis exam not relevant to condition”

**New version:**

“Not examined per Veteran’s request; Veteran reports normal anatomy of epididymis with no deformity or abnormality”

**5.1.5.15.Section 9 (Tumors and neoplasms), the top question is no longer designated as part a,**

**and the remaining subsections have been re-lettered.**

**5.1.5.16.Section 9, under the top question, the following sentence has been changed:**

**Old version:**

“If yes, complete the following:”

**New version:**

“If yes, complete the following section:”

**5.1.5.17.Section 11 (Diagnostic testing),the following sentence has been added to the NOTE:**

“When appropriate, provide most recent results. No specific studies are required for this examination.”

**5.1.5.18.Section 11, part a has been changed to the following:**

**Old version**

Has the Veteran had a testicular biopsy to determine the presence of spermatozoa?

Yes  No

If yes, were spermatozoa present?

Yes  No

Date of biopsy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New version**

Has a testicular biopsy been performed?

Yes  No

Date of biopsy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results:

Spermatozoa present

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### 5.1.6. PROSTATE CANCER (changed from released version ~163)

**5.1.6.1.Section 1 (Diagnosis), the following question has been removed:**

“If no, provide rationale (e.g. Veteran has never had prostate cancer):”

### 5.1.7. SKIN DISEASES (changed from released version ~172)

**5.1.7.1.Section 2 (Medical History), part c, the following sentence has been removed:**

“If yes, also complete the Tumors and Neoplasms Questionnaire.”

## 5.2. AMIE DBQ Worksheet Modifications

VBAVACO has approved modifications for the following AMIE –DBQ Worksheets.

* **DBQ HEARING LOSS AND TINNITUS**
* **DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA**
* **DBQ KIDNEY CONDITIONS (NEPHROLOGY)**
* **DBQ MALE REPRODUCTIVE SYSTEM CONDITIONS**
* **DBQ PROSTATE CANCER**
* **DBQ SKIN DISEASES**

VBAVACO has approved renaming the current "DBQ LEUKEMIA" AMIE worksheet to

"DBQ HAIRY CELL AND OTHER B-CELL LEUKEMIAS", to avoid potential confusion

with the "DBQ HEMIC AND LYMPHATIC CONDITIONS INCLUDING LEUKEMIA"

worksheet.

## 5.3. CAPRI Template Defects

The following CAPRI Template defects fixes address a word wrapping issue reported.

# 

* **DBQ HAIRY CELL AND OTHER B-CELL LEUKEMIAS (formerly DBQ LEUKEMIA)**
* **DBQ ISCHEMIC HEART DISEASE**
* **DBQ PARKINSONS**

On the **DBQ AMYOTROPHIC LATERAL SCLEROSIS (LOU GEHRIG’S DISEASE)** template,

a defect in section 4.g. has been repaired. The prompt reads “check all that apply”, but only one option

can be selected. This has been fixed to allow selection of multiple options.

## 5.4. AMIE Worksheets Defects

There are no AMIE Worksheet defects associated with this patch.

6. Disability Benefits Questionnaires (DBQs)

The following section illustrates the content of the questionnaires included in Patch DVBA\*2.7\*169.

## 6.1. DBQ Hearing Loss and Tinnitus

**1. Objective Findings**

a. Puretone thresholds in decibels (air conduction):

Instructions: Measure and record puretone threshold values in decibels at the indicated frequencies (air

conduction). Report the decibel value, which ranges from - 10 dB to 105 dB, for each of the frequencies.

Add a plus behind the decibel value when a maximum value has been reached with a failure of response

from the Veteran. In those circumstances where the average includes a failure of response at either the

maximum allowable limit (105 dB) or the maximum limits of the audiometer, use this maximum decibel

value of the failure of response in the puretone threshold average calculation.

If the Veteran could not be tested (CNT), enter CNT and state the reason why the Veteran could not be

tested. Clearly inaccurate, invalid or unreliable test results should not be reported.

The puretone threshold at 500 Hz is not used in calculating the puretone threshold average for evaluation

purposes but is used in determining whether or not for VA purposes, hearing impairment reaches the

level of a disability. The puretone threshold average requires the decibel levels of each of the required

frequencies (1000 Hz, 2000 Hz, 3000 Hz, and 4000 Hz) be recorded for the test to be valid for

determination of a hearing impairment.

**RIGHT EAR**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **A** | **B** | **C** | **D** | **E** | **F** | **G** |
| 500 Hz\* | 1000 Hz | 2000 Hz | 3000 Hz | 4000 Hz | 6000 Hz | 8000 Hz | Avg Hz (B – E)\*\* |
|  |  |  |  |  |  |  |  |

**LEFT EAR**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **A** | **B** | **C** | **D** | **E** | **F** | **G** |
| 500 Hz\* | 1000 Hz | 2000 Hz | 3000 Hz | 4000 Hz | 6000 Hz | 8000 Hz | Avg Hz (B – E) \*\* |
|  |  |  |  |  |  |  |  |

\*The puretone threshold at 500 Hz is not used in determining the evaluation but is used in determining

whether or not a ratable hearing loss exists.

\*\*The average of B, C, D, and E.

\*\*\*CNT – Could Not Test

b. Were there one or more frequency(ies) that could not be tested?

Yes  No

If yes, enter CNT in the box for frequency(ies) that could not be tested, and explain why testing could not

be done: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Validity of puretone test results:

Test results are valid.

Test results are invalid (not indicative of organic hearing loss).

If invalid, provide reason:

d. Speech Discrimination Score (Maryland CNC word list)

Instructions on pausing: Examiners should pause when necessary during speech discrimination

tests, in order to give the Veteran sufficient time to respond. This will ensure that the test results are

based on actual hearing loss rather than on the effects of other problems that might slow a Veteran’s

response. There are a variety of problems that might require pausing, for example, the presence of

cognitive impairment. It is up to the examiner to determine when to use pausing and the length of

the pauses.

|  |  |
| --- | --- |
| **RIGHT EAR** | % |
| **LEFT EAR** | % |

e. Appropriateness of Use of Speech Discrimination Score (Maryland CNC word list)

Use of speech discrimination score is appropriate for this Veteran.

The use of the speech discrimination score is not appropriate for this Veteran because of language

difficulties, cognitive problems, inconsistent speech discrimination scores, etc., that make combined

use of puretone average and speech discrimination scores inappropriate.

f. Audiologic Findings

Summary of Immittance (Tympanometry) Findings:

|  |  |  |
| --- | --- | --- |
|  | **RIGHT EAR** | **LEFT EAR** |
| Acoustic immittance | Normal  Abnormal | Normal  Abnormal |
| Ipsilateral Acoustic Reflexes | Normal  Abnormal | Normal  Abnormal |
| Contralateral Acoustic Reflexes | Normal  Abnormal | Normal  Abnormal |
| Unable to obtain/maintain seal |  |  |

**2. Diagnosis**

RIGHT EAR

Normal hearing

Conductive hearing loss ICD code: \_\_\_\_\_

Mixed hearing loss ICD code: \_\_\_\_\_

Sensorineural hearing loss (in the frequency range of 500-4000 Hz)\* ICD code: \_\_\_\_\_

Sensorineural hearing loss (in the frequency range of 6000 Hz or higher frequencies) \*\*

ICD code: \_\_\_\_\_

Significant changes in hearing thresholds in service\*\*\*

LEFT EAR

Normal hearing

Conductive hearing loss ICD code: \_\_\_\_\_

Mixed hearing loss ICD code: \_\_\_\_\_

Sensorineural hearing loss (in the frequency range of 500-4000 Hz)\* ICD code: \_\_\_\_\_

Sensorineural hearing loss (in the frequency range of 6000 Hz or higher frequencies) \*\*

ICD code: \_\_\_\_\_

Significant changes in hearing thresholds in service\*\*\*

**NOTES:**

\*The Veteran may have hearing loss at a level that is not considered to be a disability for VA purposes.

This can occur when the auditory thresholds are greater than 25 dB at one or more frequencies in the

500-4000 Hz range.

\*\* The Veteran may have impaired hearing, but it does not meet the criteria to be considered a

disability for VA purposes. For VA purposes, the diagnosis of hearing impairment is based upon

testing at frequency ranges of 500, 1000, 2000, 3000, and 4000 Hz. If there is no HL in the 500-4000

Hz range, but there is HL above 4000 Hz, check this box.

\*\*\*The Veteran may have a significant change in hearing threshold in service, but it does not meet the

criteria to be considered a disability for VA purposes. (A significant change in hearing threshold may

indicate noise exposure or acoustic trauma.)

**3. Evidence review**

In order to provide an accurate medical opinion, the Veteran’s records should be reviewed, if available.

Was the Veteran’s VA claims file reviewed?

Yes  No

If yes, list any records that were reviewed but were not included in the Veteran’s VA claims file: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, check all records reviewed as part of this examination:

Military service treatment records

Military service personnel records

Military enlistment examination

Military separation examination

Military post-deployment questionnaire

Department of Defense Form 214 Separation Documents

Veterans Health Administration medical records (VA treatment records)

Civilian medical records

Interviews with collateral witnesses (family and others who have known the Veteran before and

after military service)

Prior audiology reports

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No records were reviewed

**4. Etiology**

If present, is the Veteran’s hearing loss at least as likely as not (50% probability or greater) caused by or

a result of an event in military service?

Yes

No

Rationale (Provide rationale for either a yes or no answer): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cannot provide a medical opinion regarding the etiology of the Veteran’s hearing loss without resorting

to speculation

Provide rationale for reason speculation required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did hearing loss exist prior to the service?

Yes

No

If yes, was the pre-existing hearing loss aggravated beyond normal progression in military service?

Right ear  Yes  No

Left ear  Yes  No

Provide rationale for both yes or no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Functional impact of hearing loss**

NOTE: Ask the Veteran to describe in his or her own words the effects of disability (i.e. the current

complaint of hearing loss on occupational functioning and daily activities). Document the Veteran’s

response without opining on the relationship between the functional effects and the level of impairment

(audiogram) or otherwise characterizing the response. Do not use handicap scales.

Does the Veteran’s hearing loss impact ordinary conditions of daily life, including ability to work?

Yes  No

If yes, describe impact in the Veteran’s own words: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Remarks, if any, pertaining to hearing loss:** ­­­­­­­­­­­­­­­­

**SECTION 2: TINNITUS**

**1. Medical history**

Does the Veteran report recurrent tinnitus?

Yes  No

Date and circumstances of onset of tinnitus: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Evidence review**

In order to provide an accurate medical opinion, the Veteran’s records should be reviewed, if available.

Was the Veteran’s VA claims file reviewed?

Yes  No

If yes, list any records that were reviewed but were not included in the Veteran’s VA claims file: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, check all records reviewed as part of this examination:

Military service treatment records

Military service personnel records

Military enlistment examination

Military separation examination

Military post-deployment questionnaire

Department of Defense Form 214 Separation Documents

Veterans Health Administration medical records (VA treatment records)

Civilian medical records

Interviews with collateral witnesses (family and others who have known the Veteran before and

after military service)

Prior audiology reports

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No records were reviewed

**3. Etiology of tinnitus**

Select answer below and provide rationale where requested:

The Veteran has a diagnosis of clinical hearing loss, and his or her tinnitus is at least as likely as not

(50% probability or greater) a symptom associated with the hearing loss, as tinnitus is known to be a

symptom associated with hearing loss

Less likely than not (less than 50% probability) a symptom associated with the Veterans hearing loss

Rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At least as likely as not (50% probability or greater) caused by or a result of military noise exposure

Rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At least as likely as not (50% probability or greater) due to a known etiology (such as traumatic brain

injury)

Etiology and rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Less likely than not (less than 50% probability) caused by or a result of military noise exposure

Rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cannot provide a medical opinion regarding the etiology of the Veteran’s tinnitus without resorting to

speculation

Reason speculation required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Functional impact of tinnitus**

NOTE: Ask the Veteran to describe in his or her own words the effects of disability (i.e. the current

complaint of tinnitus on occupational functioning and daily activities). Document the Veteran’s response

without opining on the relationship between the functional effects and the level of impairment (audiogram)

or otherwise characterizing the response. Do not use handicap scales.

Does the Veteran’s tinnitus impact ordinary conditions of daily life, including ability to work?

Yes  No

If yes, describe impact in the Veteran’s own words: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Remarks, if any, pertaining to tinnitus:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Audiologist/clinician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Audiologist/clinician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State audiology/examiner license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to

complete VA’s review of the Veteran’s application.

## 6.2. DBQ Hematologic and Lymphatic Conditions, Including Leukemia

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**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.**

**1. Diagnosis**

Does the Veteran now have or has he/she ever been diagnosed with a hematologic or lymphatic condition?

Yes  No

If yes, select the Veteran’s condition(s) (check all that apply):

Acute lymphocytic leukemia (ALL) ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Acute myelogenous leukemia (AML) ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic myelogenous leukemia (CML) ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic lymphocytic leukemia (CLL) ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Hodgkin’s disease ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Non-Hodgkin’s lymphoma ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Multiple myeloma ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Myelodysplastic syndrome ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Plasmacytoma ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Anemia (such as anemia of chronic disease, aplastic anemia, hemolytic anemia, iron or vitamin-deficient

anemias, thalassemias, myelophthisic anemia, etc.)

ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Thrombocytopenia ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Polycythemia vera ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Sickle cell anemia ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

Splenectomy ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Hairy cell or other B-cell leukemia: If checked, complete Hairy cell and other B-cell leukemias

Questionnaire in lieu of this Questionnaire.

Other, specify:

Other diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there are additional diagnoses that pertain to hematologic or lymphatic conditions, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s hematologic or lymphatic condition (brief summary):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Is continuous medication required for control of a hematologic or lymphatic condition, including anemia or thrombocytopenia caused by treatment for a hematologic or lymphatic condition?

Yes  No

If yes, list only those medications required for control of the Veteran’s hematologic or lymphatic condition,

including anemia or thrombocytopenia caused by treatment for a hematologic or lymphatic condition. Provide

the name of the medication and the condition the medication is used to treat: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Indicate the status of the primary hematologic or lymphatic condition:

Active

Remission

Not applicable

**3. Treatment**

a. Has the Veteran completed any treatment or is the Veteran currently undergoing any treatment for any hematologic

or lymphatic condition, including leukemia?

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

Bone marrow transplant

If checked, provide:

Date of hospital admission and location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of hospital discharge after transplant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_

**4. Anemia and thrombocytopenia (primary, secondary, idiopathic and immune)**

Does the Veteran have anemia or thrombocytopenia, including that caused by treatment for a hematologic or

lymphatic condition?

Yes  No

If yes, complete the following:

a. Does the Veteran have anemia?

Yes  No

If yes, is the anemia caused by treatment for another hematologic or lymphatic condition?

Yes  No

If yes, provide the name of the other hematologic or lymphatic condition causing the secondary anemia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Does the Veteran have thrombocytopenia?

Yes  No

If yes, is the thrombocytopenia caused by treatment for another hematologic or lymphatic condition?

Yes  No

If yes, provide the name of the other hematologic or lymphatic condition causing the secondary

thrombocytopenia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, check all that apply:

Stable platelet count of 100,000 or more

Stable platelet count between 70,000 and 100,000

Platelet count between 20,000 and 70,000

Platelet count of less than 20,000

With active bleeding

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Does the Veteran have any complications or residuals of treatment requiring transfusion of platelets or red

blood cells?

Yes  No

If yes, indicate frequency of transfusions in the past 12 months:

None

At least once per year but less than once every 3 months

At least once every 3 months

At least once every 6 weeks

**5. Findings, signs and symptoms**

Does the Veteran currently have any findings, signs and symptoms due to a hematologic or lymphatic

disorder or to treatment for a hematologic or lymphatic disorder?

Yes  No

If yes, check all that apply:

Weakness

If checked, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Easy fatigability

If checked, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Light-headedness

If checked, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shortness of breath

If checked, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Headaches

If checked, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dyspnea on mild exertion

If checked, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dyspnea at rest

If checked, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tachycardia

If checked, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Syncope

If checked, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiomegaly

High output congestive heart failure

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Recurring infections**

Does the Veteran currently have recurring infections attributable to any conditions, complications or residuals

of treatment for a hematologic or lymphatic disorder?

Yes  No

If yes, indicate frequency of infections over past 12 months:

None

At least once per year but less than once every 3 months

At least once every 3 months

At least once every 6 weeks

**7. Polycythemia vera**

Does the Veteran have polycythemia vera?

Yes  No

If yes, check all that apply:

Stable, with or without continuous medication

Requiring phlebotomy

Requiring myelosuppressant treatment

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: If there are complications due to polycythemia vera such as hypertension, gout, stroke or thrombotic

disease, ALSO complete appropriate Questionnaire for each condition.

**8. Sickle cell anemia**

Does the Veteran have sickle cell anemia?

Yes  No

If yes, check all that apply:

Asymptomatic

In remission

With identifiable organ impairment

Following repeated hemolytic sickling crises with continuing impairment of health

Painful crises several times a year

Repeated painful crises, occurring in skin, joints, bones or any major organs

With anemia, thrombosis and infarction

Symptoms preclude other than light manual labor

Symptoms preclude even light manual labor

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Other pertinent physical findings, complications, conditions, signs and/or symptoms**

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any

conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39

square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or

symptoms?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. Diagnostic testing**

If testing has been performed and reflects Veteran’s current condition, no further testing is required.

When appropriate, provide most recent complete blood count.

a. Has laboratory testing been performed?

Yes  No

If yes, provide results:

Hemoglobin (gm/100ml): \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hematocrit: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Red blood cell (RBC) count: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

White blood cell (WBC) count: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

White blood cell differential count: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Platelet count: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Are there any other significant diagnostic test findings and/or results?

Yes  No

If yes, provide type of test or procedure, date and results (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11. Functional impact**

Do the Veteran’s hematologic or lymphatic condition(s) impact his or her ability to work?

Yes  No

If yes, describe impact of each of the Veteran’s hematologic and lymphatic conditions, providing one or more

examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to

complete VA’s review of the Veteran’s application.

## 6.3. DBQ Kidney Conditions (Nephrology)

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**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.**

**1. Diagnosis:**

Does the Veteran now have or has he/she ever been diagnosed with a kidney condition?

Yes  No

If yes, indicate diagnoses: (check all that apply)

Diabetic nephropathy ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Glomerulonephritis ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Hydronephrosis ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Interstitial nephritis ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Kidney transplant ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Nephrosclerosis ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Nephrolithiasis ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Renal artery stenosis ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Ureterolithiasis ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Neoplasm of the kidney ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Cholesterol emboli ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Cystic kidney disease ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Congenital kidney disorder ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Other inherited kidney disorder, specify: ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Other kidney condition (specify diagnosis, providing only diagnoses that pertain to kidney conditions.)

Other diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there are additional diagnoses that pertain to kidney conditions, list using above format: \_\_\_\_\_\_\_

**2. Medical history**

a. Describe the history (including cause, onset and course) of the Veteran’s kidney condition (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Does the Veteran’s treatment plan include taking continuous medication for the diagnosed condition?

Yes  No List medications taken for the diagnosed condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Renal dysfunction**

Does the Veteran have renal dysfunction? (Evidence of renal dysfunction includes either persistent

proteinuria, hematuria or GFR < 60 cc/min/1.73m2)

Yes  No

If yes, complete the following section:

a. Does the Veteran require regular dialysis?

Yes  No

b. Does the Veteran have any signs or symptoms due to renal dysfunction?

Yes  No

If yes, check all that apply:

Proteinuria (albuminuria)

If checked, indicate frequency: (check all that apply)

Recurring  Constant  Persistent

Edema (due to renal dysfunction)

If checked, indicate frequency: (check all that apply)

Some  Transient  Slight  Persistent

Anorexia (due to renal dysfunction)

Weight loss (due to renal dysfunction)

If checked, provide baseline weight (average weight for 2-year period preceding onset of disease):

\_\_\_\_\_\_\_\_\_\_\_\_

Provide current weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Generalized poor health due to renal dysfunction

Lethargy due to renal dysfunction

Weakness due to renal dysfunction

Limitation of exertion due to renal dysfunction

Able to perform only sedentary activity, due to persistent edema caused by renal dysfunction

Markedly decreased function other organ systems, especially the cardiovascular system, caused

by renal dysfunction

If checked, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Does the Veteran have hypertension and/or heart disease due to renal dysfunction or caused by any

kidney condition?

Yes  No

If yes, also complete the Hypertension and/or Heart Disease Questionnaire as appropriate.

**4. Urolithiasis**

Does the Veteran now have or has he/she ever had kidney, ureteral or bladder calculi (urolithiasis)?

Yes  No

If yes, complete the following section:

a. Indicate current/past location of calculi (check all that apply)

Kidney  Ureter  Bladder

b. Has the Veteran had treatment for recurrent stone formation in the kidney, ureter or bladder?

Yes  No

If yes, indicate treatment: (check all that apply)

Diet therapy

If checked, specify diet and dates of use: \_\_\_\_\_\_\_\_\_\_\_\_

Drug therapy

If checked, list medication and dates of use: \_\_\_\_\_\_\_\_\_\_\_\_

Invasive or non-invasive procedures

If checked, indicate average number of times per year invasive or non-invasive procedures were required:

0 to 1 per year  2 per year  > 2 per year

Date and facility of most recent invasive or non-invasive procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Does the Veteran have any signs or symptoms due to urolithiasis?

Yes  No

If yes, indicate severity (check all that apply):

No symptoms or attacks of colic

Occasional attacks of colic

Frequent attacks of colic

Causing voiding dysfunction

Requires catheter drainage

Causing infection (pyonephrosis)

Causing hydronephrosis

Causing impaired kidney function

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Urinary tract/kidney infection**

Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?

Yes  No

If yes, complete the following section:

a. Etiology of recurrent urinary tract or kidney infections: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Indicate all treatment modalities used for recurrent urinary tract or kidney infections (check all that apply):

No treatment

Long-term drug therapy

If checked, list medications used and indicate dates for courses of treatment over the past 12 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalization

If checked, indicate frequency of hospitalization:

1 or 2 per year

> 2 per year

Drainage

If checked, indicate dates when drainage performed over past 12 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Continuous intensive management

If checked, indicate types of treatment and medications used over past 12 months: \_\_\_\_\_\_

Intermittent intensive management

If checked, indicate types of treatment and medications used over past 12 months: \_\_\_\_\_\_

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Kidney transplant or removal**

Has the Veteran had a kidney transplant or removal?

Yes  No

If yes, complete the following section:

a. Has the Veteran had a kidney removed?

Yes  No

If yes, provide reason:

Kidney donation

Due to disease

Due to trauma or injury

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Has the Veteran had a kidney transplant?

Yes  No

If yes, date of transplant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of treatment facility, dates of admission and date of discharge for transplant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Tumors and neoplasms**

a. Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in

the Diagnosis section?

Yes  No

If yes, complete the following section:

b. Is the neoplasm

Benign  Malignant

c. 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: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_

d. 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 above?

Yes  No

If yes, list residual conditions and complications (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the

Diagnosis section, describe using the above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Other pertinent physical findings, complications, conditions, signs and/or symptoms**

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any

conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39

square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or

symptoms?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Diagnostic testing**

NOTE: If laboratory test results are in the medical record and reflect the Veteran’s current renal function,

repeat testing is not required. Provide testing completed appropriate to Veteran’s condition; testing indicated

below is not indicated for every kidney condition.

a. Has the Veteran had laboratory or other diagnostic studies performed?

Yes  No

If yes, provide most recent results, if available:

b. Laboratory studies

BUN: Date: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Creatinine: Date: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

EGFR: Date: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Urinalysis:

Hyaline casts: Date: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Granular casts: Date: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

RBC’s/HPF: Date: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proteinuria (albumin): Date: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spot urine for protein/creatinine ratio:

Date: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

24 hour protein (mg/day): Date: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. Spot urine microalbumin/creatinine: Date: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

e. Are there any other significant diagnostic test findings and/or results?

Yes  No

If yes, provide type of test or procedure, date and results (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. Functional impact**

Does the Veteran’s kidney condition(s), including neoplasms, if any, impact his or her ability to work?

Yes  No

If yes, describe impact of each of the Veteran’s kidney conditions, providing one or more examples: \_\_\_\_

**11. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to

complete VA’s review of the Veteran’s application.

## 6.4. DBQ Male Reproductive System Conditions

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**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.**

**1. Diagnosis:**

Does the Veteran now have or has he ever been diagnosed with any conditions of the male reproductive

system?  Yes  No

If yes, indicate diagnoses: (check all that apply)

Erectile dysfunction ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Penis, deformity (e.g., Peyronie’s) ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Testis, atrophy, one or both ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Testis, removal, one or both ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Epididymitis, chronic ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Epididymo-orchitis, chronic ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Prostate injury ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Prostate hypertrophy (BPH) ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Prostatitis, chronic ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Prostate surgical residuals (as addressed in items 3-6)

ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Neoplasms of the male reproductive system

ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Other male reproductive system condition (specify diagnosis, providing only diagnoses that pertain to male reproductive system.) ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Other diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there are additional diagnoses that pertain to the male reproductive organ conditions, list using above

format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s male reproductive organ condition(s)

(brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Does the Veteran’s treatment plan include taking continuous medication for the diagnosed condition?

Yes  No List medications taken for the diagnosed condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Has the Veteran had an orchiectomy?

Yes  No

Indicate testicle removed:  Right  Left  Both

Indicate reason for removal:

Undescended

Congenitally underdeveloped

Other, provide reason for removal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Voiding dysfunction**

Does the Veteran have a voiding dysfunction?

Yes  No

If yes, complete the following section:

a. Etiology of voiding dysfunction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Does the voiding dysfunction cause urine leakage?

Yes  No

Indicate severity (check one):

Does not require the wearing of absorbent material

Requires absorbent material which must be changed less than 2 times per day

Requires absorbent material which must be changed 2 to 4 times per day

Requires absorbent material which must be changed more than 4 times per day

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Does the voiding dysfunction require the use of an appliance?

Yes  No

If yes, describe the appliance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. Does the voiding dysfunction cause increased urinary frequency?

Yes  No

If yes, check all that apply:

Daytime voiding interval between 2 and 3 hours

Daytime voiding interval between 1 and 2 hours

Daytime voiding interval less than 1 hour

Nighttime awakening to void 2 times

Nighttime awakening to void 3 to 4 times

Nighttime awakening to void 5 or more times

e. Does the voiding dysfunction cause signs or symptoms of obstructed voiding?

Yes  No

If yes, check all that apply:

Hesitancy

If checked, is hesitancy marked?

Yes  No

Slow or weak stream

If checked, is stream markedly slow or weak?

Yes  No

Decreased force of stream

If checked, is force of stream markedly decreased?

Yes  No

Stricture disease requiring dilatation 1 to 2 times per year

Stricture disease requiring periodic dilatation every 2 to 3 months

Recurrent urinary tract infections secondary to obstruction

Uroflowmetry peak flow rate less than 10 cc/sec

Post void residuals greater than 150 cc

Urinary retention requiring intermittent catheterization

Urinary retention requiring continuous catheterization

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Urinary tract/kidney infection**

Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?

Yes  No

If yes, complete the following section:

a. Etiology of recurrent urinary tract or kidney infections: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Indicate all treatment modalities used for recurrent urinary tract or kidney infections (check all that apply):

No treatment

Long-term drug therapy

If checked, list medications used and indicate dates for courses of treatment over the past 12 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalization

If checked, indicate frequency of hospitalization:

1 or 2 per year

>2 per year

Drainage

If checked, indicate dates when drainage performed over past 12 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Continuous intensive management

If checked, indicate types of treatment and medications used over past 12 months: \_\_\_\_\_\_

Intermittent intensive management

If checked, indicate types of treatment and medications used over past 12 months: \_\_\_\_\_\_

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Erectile dysfunction**

Does the Veteran have erectile dysfunction?

Yes  No

If yes, complete the following section:

a. Etiology of erectile dysfunction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. If the Veteran has erectile dysfunction, is it as likely as not (at least a 50% probability) attributable to one of

the diagnoses in Section 1, including residuals of treatment for this diagnosis?

Yes  No

If yes, specify the diagnosis to which the erectile dysfunction is as likely as not attributable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. If the Veteran has erectile dysfunction, is he able to achieve an erection sufficient for penetration and

ejaculation (without medication)?

Yes  No

If no, is the Veteran able to achieve an erection sufficient for penetration and ejaculation (with medication)?

Yes  No

**6**. **Retrograde ejaculation**

Does the Veteran have retrograde ejaculation?

Yes  No

If yes, complete the following section:

a. Etiology of retrograde ejaculation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. If the Veteran has retrograde ejaculation, is it as likely as not (at least a 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?

Yes  No

If yes, specify the diagnosis to which the retrograde ejaculation is as likely as not attributable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Male reproductive organ infections**

Does the Veteran have a history of chronic epididymitis, epididymo-orchitis or prostatitis?

Yes  No

If yes, indicate all treatment modalities used for chronic epididymitis, epididymo-orchitis or prostatitis (check

all that apply):

No treatment

Long-term drug therapy

If checked, list medications used and indicate dates for courses of treatment over the past 12 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalization

If checked, indicate frequency of hospitalization:

1 or 2 per year

> 2 per year

Continuous intensive management

If checked, indicate types of treatment and medications used over past 12 months: \_\_\_\_\_\_

Intermittent intensive management

If checked, indicate types of treatment and medications used over past 12 months: \_\_\_\_\_\_

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Physical exam**

a. Penis

Normal

Not examined per Veteran’s request

Not examined per Veteran’s request; Veteran reports normal anatomy with no penile deformity or

abnormality

Not examined; penis exam not relevant to condition

Abnormal

If abnormal, indicate severity:

Loss/removal of half or more of penis

Loss/removal of glans penis

Penis deformity (such as Peyronie’s disease)

If checked, describe: \_\_\_\_\_\_\_\_\_\_\_

b. Testes

Normal

Not examined per Veteran’s request

Not examined per Veteran’s request; Veteran reports normal anatomy with no testicular deformity or

abnormality

Not examined; testicular exam not relevant to condition

Abnormal

If abnormal, check all that apply:

Right testicle

Size 1/3 or less of normal

Size 1/2 to 1/3 of normal

Considerably harder than normal

Considerably softer than normal

Absent

Other abnormality,

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Left testicle

Size 1/3 or less of normal

Size 1/2 to 1/3 of normal

Considerably harder than normal

Considerably softer than normal

Absent

Other abnormality,

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Epididymis

Normal

Not examined per Veteran’s request

Not examined per Veteran’s request; Veteran reports normal anatomy of epididymis with no deformity

or abnormality

Not examined; epididymis exam not relevant to condition

Abnormal

If abnormal, check all that apply:

Right epididymis

Tender to palpation

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Left epididymis

Tender to palpation

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. Prostate

Normal

Not examined per Veteran’s request

Not examined; prostate exam not relevant to condition

Abnormal

If abnormal, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Tumors and neoplasms**

Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?

Yes  No

If yes, complete the following section:

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 above?

Yes  No

If yes, list residual conditions and complications (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the

Diagnosis section, describe using the above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. Other pertinent physical findings, complications, conditions, signs and/or symptoms**

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any

conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39

square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11. Diagnostic testing**

NOTE: If imaging studies, diagnostic procedures or laboratory testing has been performed and reflects the

Veteran’s current condition, provide most recent results; no further studies or testing are required for this

examination. When appropriate, provide most recent results. No specific studies are required for this

examination.

a. Has a testicular biopsy been performed?

Yes  No

Date of biopsy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resutls:

Spermatozoa present

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Have any other imaging studies, diagnostic procedures or laboratory testing been performed and are the

results available?

Yes  No

If yes, provide type of test or procedure, date and results (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12. Functional impact**

Does the Veteran’s male reproductive system condition(s), including neoplasms, if any, impact his ability to

work?

Yes  No

If yes, describe the impact of each of the Veteran’s male reproductive system condition(s), providing one or

more examples:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to

complete VA’s review of the Veteran’s application.

## 6.5. DBQ Prostate Cancer

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**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.**

**1. Diagnosis**

Does the Veteran now have or has he ever been diagnosed with prostate cancer?

Yes  No

If yes, provide only diagnoses that pertain to prostate cancer.

Diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there are additional diagnoses that pertain to prostate cancer, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s prostate cancer condition (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_

b. Indicate status of disease:

Active

Remission

**3. Treatment**

Has the Veteran completed any treatment for prostate cancer or is the Veteran currently undergoing any treatment

for prostate cancer?

Yes  No; watchful waiting

If yes, indicate treatment type(s) (check all that apply):

Treatment completed; currently in watchful waiting status

Surgery

Prostatectomy

Radical prostatectomy

Transurethral resection prostatectomy

Other (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other surgical procedure (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of surgery: \_\_\_\_\_\_\_\_\_\_

Radiation therapy

Date of completion of treatment or anticipated date of completion: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_

Brachytherapy

Date of treatment: \_\_\_\_\_\_\_\_\_\_

Antineoplastic chemotherapy

Date of completion of treatment or anticipated date of completion: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_

   Androgen deprivation therapy (hormonal therapy)

Date of completion of treatment or anticipated date of completion: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_

Other therapeutic procedure and/or treatment (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of procedure: \_\_\_\_\_\_\_\_\_\_

Date of completion of treatment or anticipated date of completion: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_

**4. Voiding dysfunction**

Does the Veteran have a voiding dysfunction?

Yes  No

If yes, provide etiology of voiding dysfunction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the Veteran has a voiding dysfunction, complete the following questions:

a. Does the voiding dysfunction cause urine leakage?

Yes  No

Indicate severity (check one):

Does not require the wearing of absorbent material

Requires absorbent material which must be changed less than 2 times per day

Requires absorbent material which must be changed 2 to 4 times per day

Requires absorbent material which must be changed more than 4 times per day

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Does the voiding dysfunction require the use of an appliance?

Yes  No

If yes, describe the appliance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Does the voiding dysfunction cause increased urinary frequency?

Yes  No

If yes, check all that apply:

Daytime voiding interval between 2 and 3 hours

Daytime voiding interval between 1 and 2 hours

Daytime voiding interval less than 1 hour

Nighttime awakening to void 2 times

Nighttime awakening to void 3 to 4 times

Nighttime awakening to void 5 or more times

d. Does the voiding dysfunction cause signs or symptoms of obstructed voiding?

Yes  No

If yes, check all that apply:

Hesitancy

If checked, is hesitancy marked?

Yes  No

Slow or weak stream

If checked, is stream markedly slow or weak?

Yes  No

Decreased force of stream

If checked, is force of stream markedly decreased?

Yes  No

Stricture disease requiring dilatation 1 to 2 times per year

Stricture disease requiring periodic dilatation every 2 to 3 months

Recurrent urinary tract infections secondary to obstruction

Uroflowmetry peak flow rate less than 10 cc/sec

Post void residuals greater than 150 cc

Urinary retention requiring intermittent catheterization

Urinary retention requiring continuous catheterization

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Urinary tract/kidney infection**

Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?

Yes  No

If yes, provide etiology: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the Veteran has had recurrent symptomatic urinary tract or kidney infections, indicate all treatment modalities that

apply:

No treatment

Long-term drug therapy

If checked, list medications used and indicate dates for courses of treatment over the past 12 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalization

If checked, indicate frequency of hospitalization:

1 or 2 per year

> 2 per year

Drainage

If checked, indicate dates when drainage performed over past 12 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Continuous intensive management

If checked, indicate types of treatment and medications used over past 12 months: \_\_\_\_\_\_

Intermittent intensive management

If checked, indicate types of treatment and medications used over past 12 months: \_\_\_\_\_\_

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Erectile dysfunction**

a. Does the Veteran have erectile dysfunction?

Yes  No

If yes, provide etiology: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. If the Veteran has erectile dysfunction, is it as likely as not (at least a 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?

Yes  No

If yes, specify the diagnosis to which the erectile dysfunction is as likely as not attributable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. If the Veteran has erectile dysfunction, is he able to achieve an erection sufficient for penetration and ejaculation

(without medication)?

Yes  No

If no, is the Veteran able to achieve an erection sufficient for penetration and ejaculation (with medication)?

Yes  No

**7. Retrograde ejaculation**

a. Does the Veteran have retrograde ejaculation?

Yes  No

If yes, provide etiology of the retrograde ejaculation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. If the Veteran has retrograde ejaculation, is it as likely as not (at least a 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?

Yes  No

If yes, specify the diagnosis to which the retrograde ejaculation is as likely as not attributable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Residual conditions and/or complications**

a. Does the Veteran have any other residual conditions and/or complications due to prostate cancer or treatment for

prostate cancer?

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Other pertinent physical findings, complications, conditions, signs and/or symptoms**

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any

conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39

square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. Diagnostic testing**

NOTE: If laboratory test results are in the medical record and reflect the Veteran’s current condition, repeat testing

is not required.

Are there any significant diagnostic test findings and/or results?

Yes  No

If yes, provide type of test or procedure, date and results (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11. Functional impact**

Does the Veteran’s prostate cancer impact his ability to work?

Yes  No

If yes, describe the impact of the Veteran’s prostate cancer, providing one or more examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to complete

VA’s review of the Veteran’s application.

## 6.6. DBQ Skin Diseases

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN: \_\_\_

**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.**

**1. Diagnosis:**

Does the Veteran now have or has he/she ever had a skin condition?

Yes  No

If yes, provide only diagnoses that pertain to skin conditions.

Indicate the category of skin condition, and then provide specific diagnosis in that category (check all that apply):

Dermatitis or eczema

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Infectious skin conditions (including bacterial, fungal, viral, treponemal and parasitic skin conditions)

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bullous disorders

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psoriasis ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exfoliative dermatitis (erythroderma) ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cutaneous manifestations of collagen-vascular diseases

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Papulosquamous skin disorders

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vitiligo

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Keratinization skin disorders

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urticaria

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary cutaneous vasculitis

Erythema multiforme ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acne ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chloracne ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alopecia ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hyperhidrosis ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tumors and neoplasms of the skin, including malignant melanoma

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other skin condition

Other diagnosis #1: \_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other diagnosis #2: \_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other diagnosis #3: \_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there are additional diagnoses that pertain to the skin conditions, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical History**

a. Describe the history (including onset and course) of the Veteran’s skin conditions (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Do any of the Veteran’s skin conditions cause scarring or disfigurement of the head, face or neck?

Yes  No

If yes, indicate skin condition and describe scarring and/or disfigurement: \_\_\_\_\_\_\_\_\_\_\_\_\_

Also complete the Scars Questionnaire if appropriate.

c. Does the Veteran have any benign or malignant skin neoplasms (including malignant melanoma)?

Yes  No

d. Does the Veteran have any systemic manifestations due to any skin diseases (such as fever, weight loss or hypoproteinemia associated with skin conditions such as erythroderma)?

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also complete additional Questionnaires if appropriate.

**3. Treatment**

a. Has the Veteran been treated with oral or topical medications in the past 12 months for any skin condition?

Yes  No

If yes, check all that apply:

Systemic corticosteroids or other immunosuppressive medications

If checked, list medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specify condition medication used for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total duration of medication use in past 12 months:

< 6 weeks  6 weeks or more, but not constant  Constant/near-constant

Antihistamines

If checked, list medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specify condition medication used for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total duration of medication use in past 12 months:

< 6 weeks  6 weeks or more, but not constant  Constant/near-constant

Immunosuppressive retinoids

If checked, list medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specify condition medication used for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total duration of medication use in past 12 months:

< 6 weeks  6 weeks or more, but not constant  Constant/near-constant

Sympathomimetics

If checked, list medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specify condition medication used for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total duration of medication use in past 12 months:

< 6 weeks  6 weeks or more, but not constant  Constant/near-constant

Other oral medications

If checked, list medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specify condition medication used for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total duration of medication use in past 12 months:

< 6 weeks  6 weeks or more, but not constant  Constant/near-constant

Topical corticosteroids

If checked, list medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specify condition medication used for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total duration of medication use in past 12 months:

< 6 weeks  6 weeks or more, but not constant  Constant/near-constant

Other topical medications

If checked, list medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specify condition medication used for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total duration of medication use in past 12 months:

< 6 weeks  6 weeks or more, but not constant  Constant/near-constant

NOTE: If a medication is used for more than one condition, provide names of all conditions, name of medication

used for each condition, and frequency of use for each condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Has the Veteran had any treatments or procedures other than systemic or topical medications in the past 12

months for exfoliative dermatitis or papulosquamous disorders?

Yes  No

If yes, check all that apply:

PUVA (photo-chemotherapy with psoralen and ultraviolet A) treatment

If checked, specify condition treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of most recent treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total duration of treatment in past 12 months:

< 6 weeks  6 weeks or more, but not constant  Constant/near-constant

UVB (ultraviolet B phototherapy) treatment

If checked, specify condition treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of most recent treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total duration of treatment in past 12 months:

< 6 weeks  6 weeks or more, but not constant  Constant/near-constant

Electron beam therapy

If checked, specify condition treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of most recent treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total duration of treatment in past 12 months:

< 6 weeks  6 weeks or more, but not constant  Constant/near-constant

Intensive light therapy

If checked, specify condition treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of most recent treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total duration of treatment in past 12 months:

< 6 weeks  6 weeks or more, but not constant  Constant/near-constant

Other treatment

Specify treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specify condition treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of most recent treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total duration of treatment in past 12 months:

< 6 weeks  6 weeks or more, but not constant  Constant/near-constant

**4. Debilitating and non-debilitating episodes**

a. Has the Veteran had any debilitating episodes in the past 12 months due to urticaria, primary cutaneous

vasculitis, erythema multiforme, or toxic epidermal necrolysis?

Yes  No

If yes, specify condition causing debilitating episodes:

urticaria  primary cutaneous vasculitis  erythema multiforme  toxic epidermal necrolysis

Describe debilitating episodes (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of debilitating episodes in past 12 months:

1  2  3  4 or more

Characteristics of debilitating episodes

Occurred despite ongoing immunosuppressive therapy

Required treatment with intermittent systemic immunosuppressive therapy

Responded to treatment with antihistamines or sympathomimetics

b. Has the Veteran had any non-debilitating episodes of urticaria, primary cutaneous vasculitis, erythema

multiforme, or toxic epidermal necrolysis in the past 12 months?

Yes  No

If yes, specify condition causing non-debilitating episodes:

urticaria  primary cutaneous vasculitis  erythema multiforme  toxic epidermal necrolysis

Describe episodes (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of non-debilitating episodes in past 12 months:

1  2  3  4 or more

Characteristics of non-debilitating episodes

Occurred despite ongoing immunosuppressive therapy

Required treatment with intermittent systemic immunosuppressive therapy

Responded to treatment with antihistamines or sympathomimetics

NOTE: If the Veteran’s debilitating and/or non-debilitating episodes are due to more than one condition, provide

names of all conditions, indicating severity and frequency of episodes for each condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Physical exam**

a. Indicate the Veteran’s visible skin conditions; indicate the approximate total body area and approximate total

EXPOSED body area (face, neck and hands) affected on current examination (check all that apply):

Dermatitis Total body area  None  <5%  5% to <20%  20% to 40%  > 40%

EXPOSED area  None  <5%  5% to <20%  20% to 40%  > 40%

Eczema Total body area  None  <5%  5% to <20%  20% to 40%  > 40%

EXPOSED area  None  <5%  5% to <20%  20% to 40%  > 40%

Bullous disorder Total body area  None  <5%  5% to <20%  20% to 40%  > 40%

EXPOSED area  None  <5%  5% to <20%  20% to 40%  > 40%

Psoriasis Total body area  None  <5%  5% to <20%  20% to 40%  > 40%

EXPOSED area  None  <5%  5% to <20%  20% to 40%  > 40%

Infections of the skin

Total body area  None  <5%  5% to <20%  20% to 40%  > 40%

EXPOSED area  None  <5%  5% to <20%  20% to 40%  > 40%

Cutaneous manifestations of collagen-vascular disease

Total body area  None  <5%  5% to <20%  20% to 40%  > 40%

EXPOSED area  None  <5%  5% to <20%  20% to 40%  > 40%

Papulosquamous disorder

Total body area  None  <5%  5% to <20%  20% to 40%  > 40%

EXPOSED area  None  <5%  5% to <20%  20% to 40%  > 40%

The Veteran does not have any of the above listed visible skin conditions

b. For each skin condition, give specific diagnosis and describe appearance and location: \_\_\_\_\_\_\_\_\_

**6. Specific Skin Conditions**

Indicate the Veteran’s specific skin conditions and complete all applicable subsequent questions (check all that

apply):

Acne or Chloracne

If checked, indicate severity and location (check all that apply):

Superficial acne (comedones, papules, pustules, superficial cysts) of any extent

Deep acne (deep inflamed nodules and pus-filled cysts)

Affects less than 40% of face and neck

Affects 40% or more of face and neck

Affects body areas other than face and neck

Vitiligo

If checked, indicate areas affected by vitiligo:

Exposed areas affected

No exposed areas affected

Scarring alopecia

If checked, indicate percent of scalp affected:

< 20 %  20 to 40%  > 40%

Alopecia areata

If checked, indicate amount of hair loss:

Hair loss limited to scalp and face  Loss of all body hair

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hyperhidrosis

If checked, indicate severity:

Able to handle paper or tools after treatment

Unresponsive to treatment; unable to handle paper or tools

Veteran does not have any of the specific skin conditions listed above

**7. Tumors and neoplasms**

a. Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the

Diagnosis section?

Yes  No

If yes, complete the following:

b. Is the neoplasm

Benign  Malignant

c. 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: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_

d. 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 above?

Yes  No

If yes, list residual conditions and complications (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the

Diagnosis section, describe using the above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Other pertinent physical findings, complications, conditions, signs and/or symptoms**

Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms

related to any conditions listed in the Diagnosis section above?

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Functional impact**

Do any of the Veteran’s skin conditions impact his or her ability to work?

Yes  No

If yes, describe impact of each of the Veteran’s skin conditions, providing one or more examples: \_\_\_\_\_\_\_\_\_\_\_

**10. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to complete

VA’s review of the Veteran’s application.

7. Software and Documentation Retrieval

## 7.1 Software

The VistA software is being distributed as a PackMan patch message through the National Patch

Module (NPM). The KIDS build for this patch is DVBA\*2.7\*169.

## 7.2 User Documentation

The user documentation for this patch may be retrieved directly using FTP. The preferred method

is to FTP the files from:

**REDACTED**

This transmits the files from the first available FTP server. Sites may also elect to retrieve software

directly from a specific server as follows:

|  |  |  |
| --- | --- | --- |
| **OI&T Field Office** | **FTP Address** | **Directory** |
| **Albany** | REDACTED | [anonymous.software] |
| **Hines** | REDACTED | [anonymous.software] |
| **Salt Lake City** | REDACTED | [anonymous.software] |

|  |  |  |
| --- | --- | --- |
| **File Name** | **Format** | **Description** |
| **DVBA\_27\_P169\_RN.PDF** | Binary | Release Notes |
| **DVBA\_27\_P169\_DBQ\_HAIRYCELLLEUKEMIAS\_WF.DOCX** | Binary | Workflow Document |
| **DVBA\_27\_P169\_DBQ\_HEARINGLOSSTINNITUS.\_WF.DOCX** | Binary | Workflow Document |
| **DVBA\_27\_P169\_DBQ\_** **HEMICANDLYMPHATIC.WF.DOCX** | Binary | Workflow Document |
| **DVBA\_27\_P169\_DBQ\_KIDNEYCONDITIONS\_WF.DOCX** | Binary | Workflow Document |
| **DVBA\_27\_P169\_DBQ\_MALEREPRODUCTIVE\_WF.DOCX** | Binary | Workflow Document |
| **DVBA\_27\_P169\_DBQ\_PROSTATECANCER\_WF.DOCX** | Binary | Workflow Document |

## 

## 7.3 Related Documents

The VistA Documentation Library (VDL) web site will also contain the DVBA\*2.7\*169 Release Notes and

Workflow documents. This web site is usually updated within 1-3 days of the patch release date.

The VDL Web address for CAPRI documentation is: <http://www.va.gov/vdl/application.asp?appid=133>

Content and/or changes to the DBQs is communicated by the Disability Examination Management Office

(DEMO) through: <http://vbacodmoint1.vba.va.gov/bl/21/DBQ/default.asp>