

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\*175

September 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\*175. (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 and modifications

to functionality specifically designed for Patch DVBA\*2.7\*175.

Patch DVBA \*2.7\*175 (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs) introduces enhancements and updates made to the AUTOMATED MED INFO EXCHANGE (AMIE) V 2.7

package and the Compensation & Pension Record Interchange (CAPRI) application in support of the

new Compensation and Pension (C&P) Disability Benefits Questionnaires (DBQs).

# Overview

Veterans Benefits Administration Veterans Affairs Central Office (VBAVACO) has approved implementation of the following Disability Benefits Questionnaires (DBQs):

1. **DBQ ABDOMINAL, INGUINAL, AND FEMORAL HERNIAS**
2. **DBQ CHRONIC FATIGUE SYNDROME**
3. **DBQ COLD INJURY RESIDUALS**
4. **DBQ CRANIAL NERVES DISEASES**
5. **DBQ ENDOCRINE DISEASES (OTHER THAN THYROID, PARATHRYOID OR DIABETES MELLITUS)**
6. **DBQ FIBROMYALGIA**
7. **DBQ FORMER PRISONER OF WAR (POW) PORTOCAL**
8. **DBQ GENERAL MEDICAL - COMPENSATION**
9. **DBQ GENERAL MEDICAL – PENSION**
10. **DBQ GULF WAR GENERAL MEDICAL EXAMINATION**
11. **DBQ HIV-RELATED ILLNESSES**
12. **DBQ INFECTIOUS DISEASES (OTHER THAN HIV-RELATED ILLNESS,**

**CHRONIC FATIGUE SYNDROME AND TUBERCULOSIS**

1. **DBQ INITIAL EVALUATION OF RESIDUALS OF TRAUMATIC BRAIN INJURY**

**(I-TBI) DISABILITY**

1. **DBQ LOSS OF SENSE OR SMELL AND OR TASTE**
2. **DBQ NARCOLEPSY**
3. **DBQ NUTRITIONAL DEFICIENCES**
4. **DBQ ORAL AND DENTAL CONDITIONS INCLUDING MOUTH, LIPS AND TONGUE**

**(OTHER THAN TEMPOROMANDIBULAR JOINT CONDITIONS)**

1. **DBQ RESPIRATORY CONDITIONS (OTHER THAN TUBERCULOSIS AND SLEEP**

**ANPEA)**

1. **DBQ REVIEW EVALUATION OF RESIDUALS OF TRAUMATIC BRAIN INJURY**

**(R-TBI)**

1. **DBQ SEIZURE DISORDERS (EPILEPSY)**
2. **DBQ SINUSITIS, RHINITIS AND OTHER CONDITIONS OF THE NOSE,**

**THROAT, LARYNX AND PHARYNX**

1. **DBQ SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) AND OTHER AUTOIMMUNE**

**DISEASES (OTHER THAN HIV AND DIABETES MELLITUS TYPE I)**

1. **DBQ THYROID AND PARATHYROID CONDITIONS**
2. **DBQ URINARY TRACT (INCLUDING BLADDER AND URETHRA) CONDITIONS**

**(EXCLUDING MALE REPRODUCTIVE ORGANS)**

In addition to this patch it addresses the following DBQ(s) defects fixes:

* **DBQ GYNECOLOGICAL CONDITIONS**
* **DBQ INITIAL PTSD**
* **DBQ MALE REPRODUCTIVE SYSTEMS CONDITIONS**
* **DBQ PERIPHERAL NERVES CONDITIONS**
* **DBQ WRIST**

# Associated Remedy Tickets & New Service Requests

The following section lists the Remedy ticket(s) associated with this patch.

**HD0000000517164**

DVBA\*2.7\*174 VistA Patch Installation test problem - Name of veteran did not transfer

automatically to Gynecological DBQ

There are no New Service Requests associated with patch DVBA\*2.7\*175.

# Defects Fixes

Defects have been addressed and fixed in the following CAPRI DBQ templates:

* **DBQ GYNECOLOGICAL CONDITIONS**
* **DBQ INITIAL PTSD**
* **DBQ MALE REPRODUCTIVE SYSTEMS CONDITIONS**
* **DBQ PERIPHERAL NERVES CONDITIONS (NOT INCLUDING DIABETIC SENSORY-MOTOR PERIPHERAL NEUROPATHY)**
* **DBQ WRIST**

# 5. Enhancements

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

in Patch DVBA\*2.7\*175.

## 5.1. CAPRI – DBQ Template Additions

This patch includes adding new CAPRI DBQ Templates that are accessible through the Compensation

and Pension Worksheet Module (CPWM) of the CAPRI GUI application.

(VBAVACO) has approved content for the following new CAPRI Disability Benefits Questionnaires:

* **DBQ ABDOMINAL, INGUINAL, AND FEMORAL HERNIAS**
* **DBQ CHRONIC FATIGUE SYNDROME**
* **DBQ COLD INJURY RESIDUALS**
* **DBQ CRANIAL NERVES DISEASES**
* **DBQ ENDOCRINE DISEASES (OTHER THAN THYROID, PARATHRYOID OR DIABETES MELLITUS)**
* **DBQ FIBROMYALGIA**
* **DBQ FORMER PRISONER OF WAR (POW) PORTOCAL**
* **DBQ GENERAL MEDICAL - COMPENSATION**
* **DBQ GENERAL MEDICAL – PENSION**
* **DBQ GULF WAR GENERAL MEDICAL EXAMINATION**
* **DBQ HIV-RELATED ILLNESSES**
* **DBQ INFECTIOUS DISEASES (OTHER THAN HIV-RELATED ILLNESS,**

**CHRONIC FATIGUE SYNDROME AND TUBERCULOSIS**

* **DBQ INITIAL EVALUATION OF RESIDUALS OF TRAUMATIC BRAIN INJURY**

**(I-TBI) DISABILITY**

* **DBQ LOSS OF SENSE OR SMELL AND OR TASTE**
* **DBQ NARCOLEPSY**
* **DBQ NUTRITIONAL DEFICIENCES**
* **DBQ ORAL AND DENTAL CONDITIONS INCLUDING MOUTH, LIPS AND TONGUE**

**(OTHER THAN TEMPOROMANDIBULAR JOINT CONDITIONS)**

* **DBQ RESPIRATORY CONDITIONS (OTHER THAN TUBERCULOSIS AND SLEEP**

**ANPEA)**

* **DBQ REVIEW EVALUATION OF RESIDUALS OF TRAUMATIC BRAIN INJURY**

**(R-TBI)**

* **DBQ SEIZURE DISORDERS (EPILEPSY)**
* **DBQ SINUSITIS, RHINITIS AND OTHER CONDITIONS OF THE NOSE,**

**THROAT, LARYNX AND PHARYNX**

* **DBQ SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) AND OTHER AUTOIMMUNE**

**DISEASES (OTHER THAN HIV AND DIABETES MELLITUS TYPE I)**

* **DBQ THYROID AND PARATHYROID CONDITIONS**
* **DBQ URINARY TRACT (INCLUDING BLADDER AND URETHRA) CONDITIONS**

**(EXCLUDING MALE REPRODUCTIVE ORGANS)**

## 5.2. AMIE–DBQ Worksheet Additions

VBAVACO has approved content for the following new AMIE –DBQ Worksheets that are accessible through the Veterans Health Information Systems and Technology Architecture (VistA) AMIE software package.

* **DBQ ABDOMINAL, INGUINAL, AND FEMORAL HERNIAS**
* **DBQ CHRONIC FATIGUE SYNDROME**
* **DBQ COLD INJURY RESIDUALS**
* **DBQ CRANIAL NERVES**
* **DBQ ENDOCRINE DISEASES OTHER THAN DIABETES**
* **DBQ FIBROMYALGIA**
* **DBQ GENERAL MEDICAL EXAM - COMPENSATION**
* **DBQ GENERAL PENSION EXAM**
* **DBQ GULF WAR GENERAL MEDICAL EXAMINATION**
* **DBQ HIV-RELATED ILLNESS**
* **DBQ INFECTIOUS DISEASES**
* **DBQ INITIAL EVALUATION OF RESIDUALS OF TBI (I-TBI)**
* **DBQ LOSS OF SENSE OF SMELL AND TASTE**
* **DBQ NARCOLEPSY**
* **DBQ NUTRITIONAL DEFICIENCIES**
* **DBQ ORAL AND DENTAL**
* **DBQ PRISONER OF WAR PROTOCOL**
* **DBQ RESPIRATORY CONDITIONS**
* **DBQ REVIEW EVALUATION OF RESIDUALS OF TBI (R-TBI)**
* **DBQ SEIZURE DISORDERS (EPILEPSY)**
* **DBQ SINUSITIS/RHINITIS AND OTHER DISEASE OF THE NOSE, THROAT**
* **DBQ SYSTEMATIC LUPUS ERYTHEMATOUS (SLE) & OTHER IMMUNE DISOR**
* **DBQ THYROID & PARATHYROID**
* **DBQ URINARY TRACT AND BLADDER**

## 5.2. AMIE–DBQ Worksheet Modifications

VBAVACO has approved modifications for the following AMIE C&P Examination worksheets that are

accessible through the VISTA AMIE software package.

* **DBQ AMPUTATIONS**
* **DBQ AMYOTROPHIC LATERAL SCLEROSIS (LOU GEHRIG'S DISEASE)**
* **DBQ ANKLE CONDITIONS**
* **DBQ ARTERY AND VEIN CONDITIONS**
* **DBQ BACK (THORACOLUMBAR SPINE) CONDITIONS**
* **DBQ BREAST CONDITIONS AND DISORDERS**
* **DBQ CENTRAL NERVOUS SYSTEM DISEASES**
* **DBQ DIABETES MELLITUS**
* **DBQ DIABETIC SENSORY-MOTOR PERIPHERAL NEUROPATHY**
* **DBQ EAR CONDITIONS**
* **DBQ EATING DISORDERS**
* **DBQ ELBOW AND FOREARM CONDITIONS**
* **DBQ ESOPHAGEAL CONDITIONS**
* **DBQ EYE CONDITIONS**
* **DBQ FLATFOOT (PES PLANUS)**
* **DBQ FOOT MISCELLANEOUS (OTHER THAN FLATFOOT PES PLANUS)**
* **DBQ GALLBLADDER AND PANCREAS CONDITIONS**
* **DBQ GYNECOLOGICAL CONDITIONS**
* **DBQ HAIRY CELL AND OTHER B CELL LEUKEMIAS**
* **DBQ HAND AND FINGER CONDITIONS**
* **DBQ HEADACHES (INCLUDING MIGRAINE HEADACHES)**
* **DBQ HEARING LOSS AND TINNITUS**
* **DBQ HEART CONDITIONS**
* **DBQ HEMIC AND LYMPHATIC CONDITIONS INCLUDING LEUKEMIA**
* **DBQ HEPATITIS, CIRRHOSIS AND OTHER LIVER CONDITIONS**
* **DBQ HIP AND THIGH CONDITIONS**
* **DBQ HYPERTENSION**
* **DBQ INFECTIOUS INTESTINAL DISORDERS**
* **DBQ INITIAL PTSD**
* **DBQ INTESTINAL (OTHER THAN SURGICAL OR INFECTIOUS)**
* **DBQ INTESTINAL SURGERY (RESECTION, COLOSTOMY, ILEOSTOMY)**
* **DBQ ISCHEMIC HEART DISEASE**
* **DBQ KIDNEY CONDITIONS (NEPHROLOGY)**
* **DBQ KNEE AND LOWER LEG CONDITIONS**
* **DBQ MALE REPRODUCTIVE SYSTEM CONDITIONS**
* **DBQ MEDICAL OPINION 1**
* **DBQ MEDICAL OPINION 2**
* **DBQ MEDICAL OPINION 3**
* **DBQ MEDICAL OPINION 4**
* **DBQ MEDICAL OPINION 5**
* **DBQ MENTAL DISORDERS (EXCEPT PTSD AND EATING DISORDERS)**
* **DBQ MULTIPLE SCLEROSIS (MS)**
* **DBQ MUSCLE INJURIES**
* **DBQ NECK (CERVICAL SPINE) CONDITIONS**
* **DBQ NON-DEGENERATIVE ARTHRITIS**
* **DBQ OSTEOMYELITIS**
* **DBQ PARKINSONS**
* **DBQ PERIPHERAL NERVES (EXCLUDING DIABETIC NEUROPATHY)**
* **DBQ PERITONEAL ADHESIONS**
* **DBQ PERSIAN GULF AND AFGHANISTAN INFECTIOUS DISEASES**
* **DBQ PROSTATE CANCER**
* **DBQ RECTUM AND ANUS CONDITIONS**
* **DBQ REVIEW PTSD**
* **DBQ SCARS DISFIGUREMENT**
* **DBQ SHOULDER AND ARM CONDITIONS**
* **DBQ SKIN DISEASES**
* **DBQ SLEEP APNEA**
* **DBQ STOMACH AND DUODENAL CONDITIONS**
* **DBQ TEMPOROMANDIBULAR JOINT (TMJ) CONDITIONS**
* **DBQ TUBERCULOSIS**
* **DBQ WRIST CONDITIONS**

## 5.3. CAPRI Template Defects

### 5.3.1. DBQ Gynecological Conditions

**Issue**

When the DBQ GYNECOLOGICAL CONDITIONS is merged with another template the

“Veteran's name” isn't included on the report.

**Resolution**

The Veteran’s name will now appear on the report.

### 5.3.2. DBQ Initial PTSD

**Issue**

Section 3D contains an incomplete sentence.

**Resolution**

Section 3D now displays the complete sentence.

### 5.3.3. DBQ Male Reproductive Systems Conditions

**Issue**

Remove ICD code and Date of diagnosis from “Other diagnosis” option in Section 1.

**Resolution**

ICD Code and Date of diagnosis has been removed from the “Other diagnosis” option in Section 1.

### 

### 5.3.4. DBQ Peripheral Nerves Conditions (not including Diabetic Sensory-Motor

### Peripheral Neuropathy)

**Issue**

Section 6-Sensory Exam, when the “Decreased” option is checked for Left in the Upper anterior

thigh (L2) area, the data for the Thigh/knee (L3/4) data is not accurately reflected on the report.

**Resolution**

When “decreased” is chosen for Left Upper anterior thigh (L2), the data entered for Thigh/Knee

(L3/4) will be displayed accurately on the report.

**Issue**

When DBQ Peripheral Nerves Conditions (not including Diabetic Sensory-Motor Peripheral

Neuropathy) was merged with DBQ Neck (Cervical Spine) certain fields were being shared

between the templates. We were advised by VBA to remove the sharing.

**Resolution**

DBQ Peripheral Nerves Conditions (not including Diabetic Sensory-Motor Peripheral Neuropathy)

has been modified to not share fields between templates.

### 

### 5.3.5. DBQ Wrist Conditions

**Issue**

When the LEFT Wrist Palmarflexion number "70" option is checked it appears in the working

template, but it does not show up when reviewing or printing the report.

**Resolution**

When “70” is chosen for Left Wrist Palmarflexion it will accurately be displayed on the report.

### 

### 6. Disability Benefits Questionnaires (DBQs)

The following section illustrates the content of the new questionnaires included in Patch DVBA\*2.7\*175.

## 6.1. DBQ Abdominal, Inguinal and Femoral Hernias

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.**

**SECTION I. Diagnosis**

Does the Veteran now have or has he/she ever had any hernia conditions?

Yes  No

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

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

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

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

Other, specify below:

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

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

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

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

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

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

If there are additional diagnoses that pertain to inguinal, femoral or ventral hernias, list using above format: \_\_\_\_\_

**SECTION II. Medical History**

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

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

Yes  No

If yes, list only those medications used for the diagnosed condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION III. Hernia conditions**

Specify the Veteran’s hernia conditions below and complete appropriate sections.

**1.  Inguinal hernia**

If checked, complete following section:

a. Has the Veteran had surgery for an inguinal hernia?

Yes  No

If yes, indicate side and date of surgery:

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

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

b. Inguinal hernia exam (check all that apply)

Inguinal hernia present on exam

If checked, indicate side:  Right  Left

No inguinal hernia detected on exam

If checked, indicate side:  Right  Left

No true hernia protrusion

If checked, indicate side:  Right  Left

If inguinal hernia present, indicate size:

Right side:  Small  Large

Left side:  Small  Large

If inguinal hernia present, indicate ability to be reduced:

Right side:  Readily reducible  Not readily reducible

Left side:  Readily reducible  Not readily reducible

If inguinal hernia present, is there an indication for a supporting belt?

Yes  No

If yes, can hernia be supported by truss or belt?

Yes, well supported by truss or belt

If checked, indicate side well supported:  Right  Left

Not well supported by truss or belt

If checked, indicate side not well supported:  Right  Left

c. Surgical status of inguinal hernia (check all that apply):

No previous surgery but hernia appears operable and remediable

If checked, indicate side:  Right  Left

Irremediable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_

If checked, indicate side:  Right  Left

Inoperable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If checked, indicate side:  Right  Left

Recurrent hernia following surgical repair

If checked, indicate status of postoperative recurrent hernia:

Recurrent hernia appears operable and remediable

If checked, indicate side:  Right  Left

Irremediable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_

If checked, indicate side:  Right  Left

Inoperable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If checked, indicate side:  Right  Left

**2.  Femoral hernia**

If checked, complete following section:

a. Has the Veteran had surgery for a femoral hernia?

Yes  No

If yes, indicate side and date of surgery:

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

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

b. Femoral hernia exam (check all that apply)

Femoral hernia present on exam

If checked, indicate side:  Right  Left

No femoral hernia detected on exam

If checked, indicate side:  Right  Left

No true hernia protrusion

If checked, indicate side:  Right  Left

If femoral hernia present, indicate size:

Right side:  Small  Large

Left side:  Small  Large

If femoral hernia present, indicate ability to be reduced:

Right side:  Readily reducible  Not readily reducible

Left side:  Readily reducible  Not readily reducible

If femoral hernia present, is there an indication for a supporting belt?

Yes  No

If yes, can hernia be supported by truss or belt?

Yes, well supported by truss or belt

If checked, indicate side well supported:  Right  Left

Not well supported by truss or belt

If checked, indicate side not well supported:  Right  Left

c. Surgical status of femoral hernia (check all that apply):

No previous surgery but hernia appears operable and remediable

If checked, indicate side:  Right  Left

Irremediable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_

If checked, indicate side:  Right  Left

Inoperable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If checked, indicate side:  Right  Left

Recurrent hernia following surgical repair

If checked, indicate status of postoperative recurrent hernia:

Recurrent hernia appears operable and remediable

If checked, indicate side:  Right  Left

Irremediable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_

If checked, indicate side:  Right  Left

Inoperable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If checked, indicate side:  Right  Left

**3.  Ventral hernia**

If checked, complete following section:

a. Has the Veteran had surgery for a ventral hernia?

Yes  No

If yes, provide date of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Ventral hernia exam (check all that apply):

Ventral hernia present on exam

No ventral hernia detected on exam

If ventral hernia present, indicate size and characteristics (check all that apply):

Small

Large

Massive

Persistent

Healed ventral hernia or postoperative wounds with weakening of abdominal wall and indication for a supporting belt

Severe diastasis of recti muscles

Extensive diffuse destruction or weakening of muscular and fascial support of abdominal wall

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

If ventral hernia present, is there an indication for a supporting belt?

Yes  No

If yes, is it able to be supported by truss or belt?

Yes, well supported by truss or belt

Not well supported by truss or belt

c. Surgical status of ventral hernia (check all that apply):

No previous surgery but hernia appears operable and remediable

Irremediable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_

Inoperable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recurrent hernia following surgical repair

If checked, indicate status of postoperative recurrent hernia:

Recurrent hernia appears operable and remediable

Irremediable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_

Inoperable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION IV:**

**1. Other pertinent physical findings, scars, 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 related to any conditions listed in the Diagnosis section above?

Yes  No

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

**2. Diagnostic testing**

NOTE: If testing has been performed and reflects Veteran’s current condition, no further testing is required for this examination report.

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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Functional impact**

Does the Veteran’s hernia condition(s) impact his or her ability to work?

Yes  No

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

**4. 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.

## 6.2. DBQ Chronic Fatigue Syndrome

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/she ever been diagnosed with chronic fatigue syndrome?

Yes  No

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

Chronic fatigue syndrome ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Other, specify:

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

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

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

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

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

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

If there are additional diagnoses that pertain to chronic fatigue syndrome, list using above format: \_\_\_\_\_\_\_

NOTE:For VA purposes, the diagnosis of chronic fatigue syndrome requires:

a. New onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the

usual level for at least 6 months; and

b. The exclusion, by history, physical examination, and laboratory tests, of all other clinical conditions that

may produce similar symptoms; and

c. Six or more of the following: acute onset of the condition, low grade fever, non-exudative pharyngitis,

palpable or tender cervical or axillary lymph nodes, generalized muscle aches or weakness, fatigue

lasting 24 hours or longer after exercise, headaches (of a type, severity or pattern that is different from

headaches in the pre-morbid state), migratory joint pains, neuropsychological symptoms, sleep disturbance.

**2. Medical History**

a. Describe the history (including onset and course) of the Veteran’s chronic fatigue syndrome: \_\_\_\_\_\_\_\_

b. Is continuous medication required for control of chronic fatigue syndrome?

Yes  No

If yes, list only those medications required for the Veteran’s chronic fatigue syndrome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Are the Veteran’s symptoms controlled by continuous medication?

Yes  No

d. Have other clinical conditions that may produce similar symptoms been excluded by history, physical

examination and/or laboratory tests to the extent possible?

Yes  No

e. Did the Veteran have an acute onset of chronic fatigue syndrome?

Yes  No

f. Has debilitating fatigue reduced daily activity level to less than 50% of pre-illness level?

Yes  No

If yes, specify length of time daily activity level has been reduced to less than 50% of pre-illness level:

Less than 6 months  6 months or longer

**3. Findings, signs and symptoms**

a. Does the Veteran now have or has the Veteran had any findings, signs and symptoms attributable to

chronic fatigue syndrome?

Yes  No

If yes, check all that apply:

Debilitating fatigue

Low grade fever

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

Nonexudative pharyngitis

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

Palpable or tender cervical or axillary lymph nodes

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

Generalized muscle aches or weakness

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

Fatigue lasting 24 hours or longer after exercise

Headaches (of a type, severity or pattern that is different from headaches in the pre-morbid state)

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

Migratory joint pains

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

Neuropsychological symptoms

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

Sleep disturbance

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

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

b. Does the Veteran now have or has the Veteran had any cognitive impairment attributable to chronic fatigue

syndrome?

Yes  No

If yes, check all that apply:

Poor attention

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

Inability to concentrate

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

Forgetfulness

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

Confusion

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

Other cognitive impairments, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Specify frequency of symptoms:

Symptoms wax and wane

Symptoms are nearly constant

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

d. Do the Veteran’s symptoms due to chronic fatigue syndrome result in periods of incapacitation?

NOTE: For VA purposes, chronic fatigue syndrome is considered incapacitating only while it requires bed rest

and treatment by a physician.

Yes  No

If yes, indicate total duration of periods of incapacitation over the past 12 months:

Less than 1 week

At least 1 but less than 2 weeks

At least 2 but less than 4 weeks

At least 4 but less than 6 weeks

At least 6 weeks total duration per year

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

e. Do the Veteran’s symptoms due to chronic fatigue syndrome restrict routine daily activities as compared to

the pre-illness level?

Yes  No

If yes, specify % of restriction (check all that apply):

Symptoms restrict routine daily activities by less than 25% of the pre-illness level (more than 75% of

the pre-illness level of activities are not restricted)

Symptoms restrict routine daily activities to 50% to 75% of the pre-illness level

Symptoms restrict routine daily activities to less than 50% of the pre-illness level

Symptoms are so severe as to restrict routine daily activities almost completely

Symptoms are so severe as to occasionally preclude self-care

If checked, described frequency with which this occurs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**4. Other pertinent physical findings, scars, 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 of chronic fatigue syndrome?

Yes  No

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

**5. Diagnostic testing**

NOTE: If diagnostic test results are in the medical record and reflect the Veteran’s current chronic fatigue

syndrome, 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Functional impact**

Does the Veteran’s chronic fatigue syndrome impact his or her ability to work?

Yes  No

If yes, describe the impact of the Veteran’s chronic fatigue syndrome, providing one or more examples: \_\_\_

**7. 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 Cold Injury Residuals

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 any cold injury(ies)?

Yes  No

If yes, provide only diagnoses that pertain to cold injury(ies).

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 the cold injury, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical History:**

a. Describe the history (including circumstances of onset, body parts affected, signs and symptoms at time of

cold injury, treatment initially and currently, including non-medical measures such as moving to a warmer

climate, wearing extra socks, etc., and course) of the Veteran’s cold injury (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Dominant Hand:

Right  Left  Ambidextrous

**3. Signs and symptoms**

Check all that apply:

Right hand

Arthralgia or other pain  Numbness

Cold sensitivity  Tissue loss

Nail abnormalities  Color changes

Locally impaired sensation  Hyperhidrosis

X-ray abnormalities

Osteoarthritis

Osteoporosis

Subarticular punched out lesions

Left hand

Arthralgia or other pain  Numbness

Cold sensitivity  Tissue loss

Nail abnormalities  Color changes

Locally impaired sensation  Hyperhidrosis

X-ray abnormalities

Osteoarthritis

Osteoporosis

Subarticular punched out lesions

Right foot

Arthralgia or other pain  Numbness

Cold sensitivity  Tissue loss

Nail abnormalities  Color changes

Locally impaired sensation  Hyperhidrosis

X-ray abnormalities

Osteoarthritis

Osteoporosis

Subarticular punched out lesions

Left foot

Arthralgia or other pain  Numbness

Cold sensitivity  Tissue loss

Nail abnormalities  Color changes

Locally impaired sensation  Hyperhidrosis

X-ray abnormalities

Osteoarthritis

Osteoporosis

Subarticular punched out lesions

Right ear

Pain  Numbness

Cold sensitivity  Tissue loss

Color changes  Locally impaired sensation

Hyperhidrosis

Left ear

Pain  Numbness

Cold sensitivity  Tissue loss

Color changes  Locally impaired sensation

Hyperhidrosis

Nose

Pain  Numbness

Cold sensitivity  Tissue loss

Color changes  Locally impaired sensation

Hyperhidrosis

Other (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Arthralgia or other pain  Numbness

Cold sensitivity  Tissue loss

Nail abnormalities  Color changes

Locally impaired sensation  Hyperhidrosis

X-ray abnormalities

Osteoarthritis

Osteoporosis

Subarticular punched out lesions

If there are additional affected body parts, list using the above format: \_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: If there are amputations of fingers or toes, or complications such as squamous cell carcinoma at the

site of a cold injury scar, or peripheral neuropathy, and other disabilities that may be the residual effects of

cold injury, such as Raynaud’s phenomenon, muscle atrophy, etc., also complete appropriate

Questionnaire(s).

**4. Diagnostic testing**

The diagnoses of osteoporosis, subarticular punched out lesions, or osteoarthritis must be confirmed by

X-rays. Once these abnormalities have been documented, no further imaging studies are indicated.

Are there X-rays of the affected areas?

Yes  No

If yes, provide the date of the most recent x-rays for each affected body part: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, arrange for X-rays to be taken.

**5. Assistive devices**

a. Does the Veteran use any assistive device(s) as a normal mode of locomotion, although occasional

locomotion by other methods may be possible?

Yes  No

If yes, identify assistive device(s) used (check all that apply and indicate frequency):

Wheelchair Frequency of use:  Occasional  Regular  Constant

Brace(s) Frequency of use:  Occasional  Regular  Constant

Crutch(es) Frequency of use:  Occasional  Regular  Constant

Cane(s) Frequency of use:  Occasional  Regular  Constant

Walker Frequency of use:  Occasional  Regular  Constant

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

Frequency of use:  Occasional  Regular  Constant

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for

each condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Remaining effective function of the extremities**

Due to cold injury(ies), is there functional impairment of an extremity such that no effective function remains

other than that which would be equally well served by an amputation with prosthesis? (Functions of the upper

extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and

propulsion, etc.)

Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.

No

If yes, indicate extremity(ies) (check all extremities for which this applies)**:**

Right upper  Left upper  Right lower  Left lower

For each checked extremity, describe loss of effective function, identify the condition causing loss of

function, and provide specific examples (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Other pertinent physical findings, scars, 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 resulting from a cold injury?

Yes  No

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

**8. Functional impact**

Based on your examination and/or the Veteran’s history, does the Veteran’s cold injury impact his or her ability to work?

Yes  No

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

**9. 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 Cranial Nerves 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 been diagnosed with a cranial nerve condition?

Yes  No

If yes, provide only diagnoses that pertain to cranial nerve conditions:

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 cranial nerves, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEFINITIONS: For VA purposes, neuralgia indicates a condition characterized by a dull and intermittent

pain of typical distribution so as to identify the nerve, while neuritis is characterized by loss of reflexes,

muscle atrophy, sensory disturbances and constant pain, at times excruciating.

NOTE: Disabilities from lesions of peripheral portions of first, second, third, fourth, sixth, and eigth nerve

s are addressed in other DBQs.

**2. Medical History**

a. Describe the history (including etiology, onset and course) of the Veteran’s cranial nerve condition

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

b. Indicate the cranial nerves affected by the Veteran’s condition (check all that apply):

Cranial nerve I (olfactory)

If checked, complete the Loss of Sense of Smell and Taste DBQ in lieu of this Questionnaire.

Cranial nerves II-IV

If checked, complete Eye DBQ

Cranial nerve V (trigeminal)

Cranial nerve VII (facial)

Cranial nerve IX (glossopharyngeal)

Cranial nerve X (vagus)

Cranial nerve XI (spinal accessory)

Cranial nerve XII (hypoglossal)

**3. Symptoms**

Does the Veteran have symptoms attributable to any cranial nerve conditions affecting cranial nerves V-XII?

Yes  No

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

Constant pain, at times excruciating

If checked, indicate location and severity:

Upper face, eye and/or forehead

Right  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Mid face

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Lower face

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Side of mouth and throat

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Intermittent pain

If checked, indicate location and severity:

Upper face, eye and/or forehead

Right  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Mid face

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Lower face

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Side of mouth and throat

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Dull pain

If checked, indicate location and severity:

Upper face, eye and/or forehead

Right  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Mid face

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Lower face

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Side of mouth and throat

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Paresthesias and/or dysesthesias

If checked, indicate location and severity:

Upper face, eye and/or forehead

Right  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Mid face

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Lower face

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Side of mouth and throat

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Numbness

If checked, indicate location and severity:

Upper face, eye and/or forehead

Right  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Mid face

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Lower face

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Side of mouth and throat

Right:  Mild  Moderate  Severe

Left:  Mild  Moderate  Severe

Difficulty chewing

If checked, indicate severity:

Mild  Moderate  Severe

Difficulty swallowing

If checked, indicate severity:

Mild  Moderate  Severe

Difficulty speaking

If checked, indicate severity:

Mild  Moderate  Severe

Increased salivation

If checked, severity:

Mild  Moderate  Severe

Decreased salivation

If checked, severity:

Mild  Moderate  Severe

Gastrointestinal symptoms

If checked, severity:

Mild  Moderate  Severe

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

Other symptoms

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

**4. Muscle strength testing**

Rate strength using the following levels to estimate strength of muscle groups. This summary provides

useful information for VA purposes.

All normal

Cranial nerve V: (Motor: muscles of mastication; clench jaw, palpate masseter, temporalis)

Right:  Normal  Mild  Moderate  Severe  Complete paralysis

Left:  Normal  Mild  Moderate  Severe  Complete paralysis

Cranial nerve VII, upper portion of face: (Motor: muscles of facial expression; shuts eyes tightly)

Right:  Normal  Mild  Moderate  Severe  Complete paralysis

Left:  Normal  Mild  Moderate  Severe  Complete paralysis

Cranial nerve VII, lower portion of face: (Motor: muscles of facial expression; grins)

Right:  Normal  Mild  Moderate  Severe  Complete paralysis

Left:  Normal  Mild  Moderate  Severe  Complete paralysis

Cranial nerve IX, X: (Motor: swallow, cough, palate elevation; “say ah”, gag reflex if indicated)

Right:  Normal  Mild  Moderate  Severe  Complete paralysis

Left:  Normal  Mild  Moderate  Severe  Complete paralysis

Cranial nerve XI: (Motor: trapezius, sternocleidomastoid; shoulder shrug, turn head against resistance)

Right:  Normal  Mild  Moderate  Severe  Complete paralysis

Left:  Normal  Mild  Moderate  Severe  Complete paralysis

Cranial nerve XII: (Motor: protrude tongue, move tongue from side to side)

Right:  Normal  Mild  Moderate  Severe  Complete paralysis

Left:  Normal  Mild  Moderate  Severe  Complete paralysis

**5. Sensory exam**

Provide results for sensation testing to light touch for facial sensation:

All normal

Cranial nerve V:

Upper face and forehead

Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Mid face:

Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Lower face:

Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

**6. Cranial nerve summary evaluation**

a. For the following cranial nerves, indicate the cranial nerves affected and severity (“degree of

paralysis”), basing the responses on symptoms and findings from the above exam. This section provides

an estimation of the severity of the Veteran’s cranial nerve condition, which is useful for VA purposes.

NOTE: For VA purposes, the term “incomplete paralysis" indicates a degree of lost or impaired function

substantially less than complete paralysis, whether due to varied level of the nerve lesion or to partial regeneration.

Cranial nerve V (trigeminal)

Right:  Not affected  Incomplete, moderate  Incomplete, severe  Complete

Left:  Not affected  Incomplete, moderate  Incomplete, severe  Complete

Cranial nerve VII (facial):

Right : Not affected  Incomplete, moderate  Incomplete, severe  Complete

Left:  Not affected  Incomplete, moderate  Incomplete, severe  Complete

Cranial nerve IX (glossopharyngeal):

Right:  Not affected  Incomplete, moderate  Incomplete, severe  Complete

Left:  Not affected  Incomplete, moderate  Incomplete, severe  Complete

Cranial nerve X (vagus):

Right:  Not affected  Incomplete, moderate  Incomplete, severe  Complete

Left:  Not affected  Incomplete, moderate  Incomplete, severe  Complete

Cranial nerve XI (spinal accessory):

Right:  Not affected  Incomplete, moderate  Incomplete, severe  Complete

Left:  Not affected  Incomplete, moderate  Incomplete, severe  Complete

Cranial nerve XII (hypoglossal):

Right: Not affected  Incomplete, moderate  Incomplete, severe  Complete

Left:  Not affected  Incomplete, moderate  Incomplete, severe  Complete

b. Does the Veteran have any other significant signs or symptoms of a cranial nerve condition, such as

impaired salivation or lacrimation due to cranial nerve VII condition?

Yes  No

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

**7. Other pertinent physical findings, scars, 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 related to any conditions listed in the Diagnosis section above?

Yes  No

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

**8. Diagnostic testing**

For the purpose of this examination, diagnostic or imaging studies are usually not required to diagnose

specific cranial nerve conditions in the appropriate clinical setting.

a. Have imaging or other diagnostic studies been performed and are the results available?

Yes  No

If yes, provide type of study, date and results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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): \_\_\_\_\_\_\_\_\_

**9. Functional impact**

Does the Veteran’s cranial nerve condition impact his or her ability to work?

Yes  No

If yes, describe impact of each of the Veteran’s cranial nerve 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.

## 6.5. DBQ Endocrine Diseases (other than Thyroid, Parathyroid or Diabetes Mellitus)

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 have or has he/she ever had an endocrine condition?

Yes  No

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

Cushing’s syndrome ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_

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

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

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

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

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

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

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

Other, specify:

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

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

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

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

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

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

If there are additional diagnoses that pertain to endocrine condition(s), list using above format: \_\_\_\_\_\_\_\_\_\_\_

**NOTE:** If there are any cardiovascular, psychiatric, vision, skin or skeletal complications

attributable to an endocrine condition, ALSO complete appropriate Questionnaires if indicated.

**2. Medical history**

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

b. Is continuous medication required for control of an endocrine condition?

Yes  No

If yes, specify the condition and list only those medications required for the Veteran’s endocrine

condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Has the Veteran had surgery for an endocrine condition?

Yes  No

If yes, specify the condition and type of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

d. Has the Veteran had any other type of treatment for an endocrine condition?

Yes  No

If yes, specify the condition and type of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**3. Cushing’s syndrome**

Does the Veteran have any findings, signs or symptoms attributable to Cushing’s syndrome?

Yes  No

If yes, check all that apply:

Striae

Obesity

Moon face

Glucose intolerance

Vascular fragility

Loss of muscle strength

Enlargement of pituitary or adrenal gland

As active, progressive disease including loss of muscle strength

Osteoporosis

Hypertension

Weakness

For all checked conditions or for any other conditions, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Acromegaly**

Does the Veteran currently have any findings, signs or symptoms attributable to acromegaly?

Yes  No

If yes, check all that apply:

Enlargement of acral parts

Overgrowth of long bones

Enlarged sella turcica

Arthropathy

Glucose intolerance

Hypertension

If checked, provide BPx3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Evidence of increased intracranial pressure (such as visual field defect)

Cardiomegaly

For all checked conditions or for any other conditions, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Diabetes insipidus**

Does the Veteran currently have any findings, signs or symptoms attributable to diabetes insipidus?

Yes  No

If yes, check all that apply:

Polyuria

Near-continuous thirst

Episodes of dehydration NOT requiring parenteral hydration in past 12 months

If checked, indicate frequency of documented episodes in past 12 months:

0  1  2  More than 2

Episodes of dehydration requiring parenteral hydration in past 12 months

If checked, indicate frequency of documented episodes in past 12 months:

0  1  2  More than 2

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

**6. Addison’s disease (adrenal cortical hypofunction)**

Does the Veteran currently have any findings, signs or symptoms attributable to Addison’s

disease?

Yes  No

If yes, check all that apply:

Corticosteroid therapy required for control

Weakness

Fatigability

Addisonian crisis (acute adrenal insufficiency)

If checked, indicate frequency of Addisonian crises in past 12 months:

0  1  2  3  4  5  More than 5

Addisonian “episodes”

If checked, indicate frequency of Addisonian “episodes” in past 12 months:

0  1  2  3  4  5  More than 5

For all checked conditions or for any other conditions, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE:An Addisonian crisis consists of the rapid onset of peripheral vascular collapse (with acute

hypotension and shock), with findings that may include anorexia; nausea; vomiting; dehydration;

profound weakness; pain in the abdomen; legs and back; fever, apathy and depressed mentation

with possible progression to coma, renal shutdown and death.

For VA purposes, an Addisonian “episode” is a less acute and less severe event than an

Addisonian crisis and may consist of anorexia, nausea, vomiting, diarrhea, dehydration,

weakness, malaise, orthostatic hypotension or hypoglycemia, but no peripheral vascular collapse.

**7. Other endocrine conditions**

Does the Veteran have any other endocrine conditions?

Yes  No

If yes, specify condition and describe any current findings, signs and symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Other pertinent physical findings, scars, 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 related to any conditions listed in the Diagnosis section above?

Yes  No

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

**10. Diagnostic testing**

NOTE: If diagnostic test results are in the medical record and reflect the Veteran’s current

endocrine condition, repeat testing is not required.

a. Have imaging studies been performed?

Yes  No

If yes, check all that apply:

Magnetic resonance imaging (MRI) Date: \_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_

Computed tomography (CT) Date: \_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_

b. Has laboratory testing been performed?

Yes  No

If yes, indicate type of test, date and results:

Type of test: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_

c. 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**

Does the Veteran’s endocrine condition impact his or her ability to work?

Yes  No

If yes, describe the impact of each of the Veteran’s endocrine 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.

## 6.6. DBQ Fibromyalgia

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 fibromyalgia?

Yes  No

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

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

Other, specify:

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

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

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

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

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

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

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

NOTE: Fibromyalgia may also be called fibrositis or primary fibromyalgia syndrome.

**2. Medical history**

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

b. Is the Veteran currently undergoing treatment for this condition?

Yes  No

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

c. Is continuous medication required for control of fibromyagia symptoms?

Yes  No

If yes, list only those continuous medications required for the Veteran’s fibromyalgia condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. Are the Veteran’s fibromyalgia symptoms refractory to therapy?

Yes  No

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

**3. Findings, signs and symptoms**

a. Does the Veteran currently have any findings, signs or symptoms attributable to fibromyalgia?

Yes  No

If yes, check all that apply:

Widespread musculoskeletal pain

(For VA purposes widespread pain in fibromyalgia means pain in both the left and right sides of the

body, that is both above and below the waist, and that affects both the axial skeleton (i.e*.*, cervical

spine, anterior chest, thoracic spine or low back) and the extremities.)

Stiffness

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

Muscle weakness

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

Fatigue

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

Sleep disturbances

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

Paresthesias

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

Headache

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

Depression

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

If checked, a Mental Disorders Questionnaire must ALSO be completed.

Anxiety

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

Irritable bowel symptoms

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

Raynaud’s-like symptoms

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

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

b. Indicate frequency of fibromyalgia symptoms (check all that apply):

No symptoms

Episodic with exacerbations

Present more than one-third of the time

Constant or nearly constant

Often precipitated by environmental or emotional stress or overexertion

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

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

c. Does the Veteran have tender points for pain?

Yes  No

If yes, check all that apply:

Low cervical region: at anterior aspect of the interspaces between transverse processes of C5-C7

If checked, indicate side:  Right  Left  Both

Second rib: at second costochondral junction

If checked, indicate side:  Right  Left  Both

Occiput: at suboccipital muscle insertion

If checked, indicate side:  Right  Left  Both

Trapezius muscle: midpoint of upper border

If checked, indicate side:  Right  Left  Both

Supraspinatus muscle: above medial border of the scapular spine

If checked, indicate side:  Right  Left  Both

Lateral epicondyle: 2 cm distal to lateral epicondyle

If checked, indicate side:  Right  Left  Both

Gluteal: at upper outer quadrant of buttocks

If checked, indicate side:  Right  Left  Both

Greater trochanter: posterior to greater trochanteric prominence

If checked, indicate side:  Right  Left  Both

Knee: medial joint line

If checked, indicate side:  Right  Left  Both

Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If checked, indicate side:  Right  Left  Both

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

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

related to any conditions listed in the Diagnosis section above?

Yes  No

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

**5. Diagnostic testing**

NOTE: If diagnostic 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Functional impact**

Does the Veteran’s fibromyalgia impact his or her ability to work?

Yes  No

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

**7. 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.

## 6.7. DBQ Former Prisoner Of War (POW) Protocol

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 one or more of the conditions listed below?

Yes  No

If yes, check all that apply:

**Atherosclerotic heart disease or hypertensive vascular disease** (including hypertensive heart

disease) and their complications (including myocardial infarction, congestive heart failure, arrhythmia)

– (Relevant Questionnaires: IHD; Heart Disease)

**Avitaminosis** -- (Relevant Questionnaire: Nutritional Deficiencies)

**Beriberi** (including beriberi heart disease) -- (Relevant Questionnaires: Nutritional Deficiencies; Heart

Disease, if indicated)

**Chronic dysentery** -- (Relevant Questionnaire: appropriate Intestines questionnaire)

**Cirrhosis of the liver** -- (Relevant Questionnaire: Hepatitis, Cirrhosis and other Liver Conditions)

**Dysthymic disorder** (Depressive neurosis) -- (Relevant Questionnaire: Mental

Disorder)

**Helminthiasis** -- (Relevant Questionnaires: Nutritional Deficiencies; Infectious Diseases;

Hematological and Lymphatic)

**Irritable bowel syndrome** --(Relevant Questionnaire: Intestines (other than surgical or infectious)

**Malnutrition and/or other nutritional deficiency** (including optic atrophy associated with

malnutrition) -- (Relevant Questionnaires: Nutritional Deficiencies; Eye, if indicated)

**Organic residuals of frostbite** (if it is determined that the Veteran was interned in climatic

conditions consistent with the occurrence of frostbite) -- (Relevant Questionnaire: Cold Injury Residuals)

**Osteoporosis** -- (Relevant Questionnaires: select appropriate Spine or joint questionnaire)

**Pellagra** -- (Relevant Questionnaire: Nutritional Deficiencies)

**Peptic ulcer disease** -- (Relevant Questionnaire: Stomach and Duodenal Conditions)

**Peripheral neuropathy** (except where directly related to infectious causes) -- (Relevant

Questionnaire: Peripheral Nerves)

**Post-traumatic osteoarthritis** -- (Relevant Questionnaires: select appropriate spine or joint questionnaire)

**Psychosis** and/or any of the **anxiety states** -- (Relevant Questionnaires: Initial Post-Traumatic Stress

Disorder; Mental Disorder)

**Stroke** and its complications -- (Relevant Questionnaires: Central Nervous System &

Neuromuscular Diseases; Cranial Nerves)

**Note:** If a Veteran is a former prisoner of war, the diseases listed above shall be considered for service connection if they become manifest *[or “if the Veteran manifests them”]* at any time after service.

**2. Medical history**

Perform a thorough review of all body systems. Based on this review, complete the sections below that

pertain to the Veteran’s symptoms. Complete the appropriate Questionnaire(s) based on your selections

below.

i. Is there a skin and/or scar condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Skin Diseases

Scars

ii. Is there a hemic and/or lymphatic condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Hematologic (including Anemia) and Lymphatic (Including Non-Hodgkin’s Lymphoma)

Hairy Cell & Other B-Cell Leukemias

iii. Is there an eye condition?  Yes  No

If yes, complete the Eyes Questionnaire.

Note:Vision evaluations must be conducted by a specialist.

iv. Is there an ear condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Hearing Loss and Tinnitus

Ear Conditions

Note:Audio evaluations must be conducted by a specialist.

v. Is there a nose, sinuses, mouth and/or throat condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Sinusitis/Rhinitis and Other Conditions of the Nose, Throat, Larynx and Pharynx

Loss of Sense of Smell and/or Taste

Oral and Dental Conditions (including mouth, lips and tongue)

Temporomandibular Joint

vi. Is there a respiratory condition other than tuberculosis?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Respiratory Conditions (other than tuberculosis and sleep apnea)

Sleep Apnea

vii. Is there a disorder of the breast?  Yes  No

If yes, complete the Disorders of the Breast Questionnaire.

viii. Is there a cardiovascular condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Ischemic Heart Disease

Artery & Vein Conditions (vascular diseases including varicose veins)

Hypertension

Heart Disease (including arrhythmias, valvular disease, and cardiac surgery)

ix. Is there an abdomen and/or digestive condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Esophageal Disorders (GERD and Hiatal Hernia)

Gallbladder and Pancreas

Infectious Intestinal Conditions

Intestinal Surgery

Intestinal Conditions (other than Surgical and Infectious)

Hepatitis, Cirrhosis, and Other Liver Conditions

Peritoneal Adhesions

Stomach and Duodenal Conditions

Abdominal, Inguinal, and Femoral Hernias

Rectum and Anus (Including Hemorrhoids)

x. Is there a male genitourinary condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Kidney Conditions

Male Reproductive Organs

Prostate Cancer

Urinary Tract (including Bladder and Urethral) Conditions

xi. Is there a female genitourinary condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Gynecological Conditions

Kidney Conditions

Urinary Tract (including Bladder and Urethral) Conditions

xii. Is there a musculoskeletal condition?  Yes  No

1. If yes, check all that apply and complete the corresponding Questionnaire(s):

Spine

Back (Thoracolumbar Spine) Conditions

Neck (Cervical Spine) Conditions

Upper Extremities

Hands and Fingers

Wrist

Elbow and Forearm

Shoulder and Arm

Lower Extremities

Flatfeet

Foot (other than Flatfeet)

Ankle

Knee and Lower Leg

Hip and Thigh

Miscellaneous

Amputations

Fibromyalgia

Osteomyelitis

Muscle Injuries

Non-degenerative Arthritis (including inflammatory, autoimmune, crystalline and infectious arthritis)

and Dysbaric Osteonecrosis

b. If yes, are there joint manifestations of osteoporosis/osteopenia?  Yes  No

If yes, complete appropriate Questionnaire for affected joint(s)/spine.

xiii. Is there an endocrine and/or metabolic condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Diabetes Mellitus

Thyroid and Parathyroid

Endocrine Diseases (other than Thyroid, Parathyroid, or Diabetes Mellitus)

xiv. Is there a neurological condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Parkinson’s Disease

Amyotrophic Lateral Sclerosis (ALS)

Cranial Nerves Diseases

Diabetic Sensory-Motor Peripheral Neuropathy

Disease of the Central Nervous System

Fibromyalgia

Narcolepsy

Headaches (including Migraine Headaches)

Multiple Sclerosis (MS)

Peripheral Nerves

Seizure Disorders (Epilepsy)

Initial Evaluation of Residuals of Traumatic Brain Injury (I-TBI)

(The I-TBI Questionnaire can only be completed by a VHA specialist)

Review Evaluation of Residuals of Traumatic Brain Injury (R-TBI)

xv. Is there a psychiatric condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Eating Disorders

Initial PTSD (Initial PTSD Questionnaire can only be completed by VHA specialist)

Mental Disorders (Other Than PTSD)

Review PTSD

Note:Mental evaluations must be conducted by a specialist.

xvi. Is there an infectious disease, an immune disorder and/or nutritional deficiency?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Chronic Fatigue Syndrome

Persian Gulf and Afghanistan Infectious Diseases

HIV and Related Illnesses

Infectious Disease

Systemic Lupus Erythematosus and other Immune Disorders

Nutritional Deficiencies

Tuberculosis

xvii. Additional Questionnaires

Check all that apply and complete the corresponding Questionnaire(s):

Cold Injury Residuals

Gulf War Protocol (Undiagnosed Illness and Unexplained Chronic Multisymptom Illness)

**3. Diagnoses that are not addressed on other questionnaires.**

Provide a list of the Veteran’s diagnoses that have not been addressed on other questionnaires:

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, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Functional impact**

Does the Veteran’s condition(s) that are etiologically related to his or her prisoner of war experience impact his

or her ability to work?

Yes  No

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

**5. 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.

## 6.8. DBQ General Medical - Compensation

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. Medical history**

Perform a thorough review of all body systems. Based on this review, complete the sections below that

pertain to the Veteran’s symptoms. Complete the appropriate Questionnaire(s) based on your selections

below.

i. Is there a skin and/or scar condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Skin Diseases

Scars

ii. Is there a hemic and/or lymphatic condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Hematologic (including Anemia) and Lymphatic (Including Non-Hodgkin’s Lymphoma)

Hairy Cell & Other B-Cell Leukemias

iii. Is there an eye condition?  Yes  No

If yes, complete the Eyes Questionnaire.

Note:Vision evaluations must be conducted by a specialist.

iv. Is there an ear condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Hearing Loss and Tinnitus

Ear Conditions

Note:Audio evaluations must be conducted by a specialist.

v. Is there a nose, sinuses, mouth and/or throat condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Sinusitis/Rhinitis and Other Conditions of the Nose, Throat, Larynx and Pharynx

Loss of Sense of Smell and/or Taste

Oral and Dental Conditions (including mouth, lips and tongue)

Temporomandibular Joint

vi. Is there a respiratory condition other than tuberculosis?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Respiratory Conditions (other than tuberculosis and sleep apnea)

Sleep Apnea

vii. Is there a disorder of the breast?  Yes  No

If yes, complete the Disorders of the Breast Questionnaire.

viii. Is there a cardiovascular condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Ischemic Heart Disease

Artery & Vein Conditions (vascular diseases including varicose veins)

Hypertension

Heart Disease (including arrhythmias, valvular disease, and cardiac surgery)

ix. Is there an abdomen and/or digestive condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Esophageal Disorders (GERD and Hiatal Hernia)

Gallbladder and Pancreas

Infectious Intestinal Conditions

Intestinal Surgery

Intestinal Conditions (other than Surgical and Infectious)

Hepatitis, Cirrhosis, and Other Liver Conditions

Peritoneal Adhesions

Stomach and Duodenal Conditions

Abdominal, Inguinal, and Femoral Hernias

Rectum and Anus (Including Hemorrhoids)

x. Is there a male genitourinary condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Kidney Conditions

Male Reproductive Organs

Prostate Cancer

Urinary Tract (including Bladder and Urethral) Conditions

xi. Is there a female genitourinary condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Gynecological Conditions

Kidney Conditions

Urinary Tract (including Bladder and Urethral) Conditions

xii. Is there a musculoskeletal condition?  Yes  No

1. If yes, check all that apply and complete the corresponding Questionnaire(s):

Spine

Back (Thoracolumbar Spine) Conditions

Neck (Cervical Spine) Conditions

Upper Extremities

Hands and Fingers

Wrist

Elbow and Forearm

Shoulder and Arm

Lower Extremities

Flatfeet

Foot (other than Flatfeet)

Ankle

Knee and Lower Leg

Hip and Thigh

Miscellaneous

Amputations

Fibromyalgia

Osteomyelitis

Muscle Injuries

Non-degenerative Arthritis (including inflammatory, autoimmune, crystalline and infectious arthritis)

and Dysbaric Osteonecrosis

b. Are there joint manifestations of osteoporosis/osteopenia?  Yes  No

If yes, complete appropriate Questionnaire for affected joint(s)/spine)

xiii. Is there an endocrine and/or metabolic condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Diabetes Mellitus

Thyroid and Parathyroid

Endocrine Diseases (other than Thyroid, Parathyroid, or Diabetes Mellitus)

xiv. Is there a neurological condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Parkinson’s Disease

Amyotrophic Lateral Sclerosis (ALS)

Cranial Nerves Diseases

Diabetic Sensory-Motor Peripheral Neuropathy

Disease of the Central Nervous System

Fibromyalgia

Narcolepsy

Headaches (including Migraine Headaches)

Multiple Sclerosis (MS)

Peripheral Nerve Disorder

Seizure Disorder (Epilepsy)

Initial Evaluation of Residuals of Traumatic Brain Injury (I-TBI)

(The I-TBI Questionnaire can only be completed by a VHA specialist)

Review Evaluation of Residuals of Traumatic Brain Injury (R-TBI)

xv. Is there a psychiatric condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Eating Disorders

Initial Evaluation of PTSD (Initial PTSD Questionnaire can only be completed by VHA

specialist)

Mental Disorders (Other Than PTSD)

Review Evaluation of PTSD

Note:Mental disorder evaluations must be conducted by a specialist.

xvi. Is there an infectious disease, an immune disorder, and/or nutritional deficiency?

Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Chronic Fatigue Syndrome

Persian Gulf and Afghanistan Infectious Diseases

HIV and Related Illnesses

Infectious Diseases

Systemic Lupus Erythematosus or other Immune Disorders

Nutritional Deficiencies

Tuberculosis

xvii. Additional Questionnaires

Check all that apply and complete the corresponding Questionnaire(s):

Cold Injury Residuals

Prisoner of War Protocol

Gulf War Protocol (Undiagnosed Illness and Unexplained Chronic Multisymptom Illness)

**2. Diagnoses that are not addressed on other questionnaires.**

Provide a list of the Veteran’s diagnoses that have not been addressed on other questionnaires:

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, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Evidence review**

Were medical or other pertinent records/evidence available for review as part of this examination?

Yes  No

If yes, indicate evidence/records reviewed as part of this examination (check all that apply):

VA claims file (C-file)

If checked, documents listed separately below that are included in a C-file do not need to be

additionally indicated.

Veterans Health Administration medical records (CPRS treatment records)

Civilian medical records

Military service treatment records

Military service personnel records

Military enlistment examination

Military separation examination

Military post-deployment questionnaire

Department of Defense Form 214 separation document

Previous disability decision letters

Correspondence and non-medical documents related to condition

Interviews with collateral witnesses (family and others who have known the Veteran before and after military service)

Medical evidence brought to exam by Veteran

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

Social and Industrial Survey or other social work survey

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

**4. 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?

Yes  No

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

**5. Functional impact of each additional diagnosis not addressed on other questionnaires.**

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

Yes  No

If yes, describe the impact of each condition(s), providing one or more examples:

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

**6. 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.

## 6.9. DBQ General Medical - Pension

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**

After your evaluation, provide a list of the Veteran’s current chronic medical conditions below:

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 disabling conditions, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical history**

1. Comment on the course, treatment, and symptoms for each diagnosis listed above:

NOTE: Mental, Dental, Vision, and Audio evaluations must be conducted by a specialist. Complete the

corresponding Questionnaire(s), as appropriate.:

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

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

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

If there are additional diagnoses, list course, treatment, and symptoms using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Is the Veteran currently a patient in a nursing home for long-term care because of disability?

Yes  No

c. Is the Veteran currently hospitalized?

Yes  No

If yes, indicate the date of entrance into the hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, indicate the length of time (months) hospitalized:

1  2  3  4  5  6  7  8  9  10  11  12 or more

**3. Employment History**

a. Is the Veteran currently employed?

Yes  No

If yes, describe the Veteran’s current employment:

Full time  Part time  Casual/Seasonal

Clinician Notes regarding current employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Does the Veteran’s above listed medical conditions prevent him or her from securing or following a substantially gainful occupation?

Yes  No

If yes, are any of these conditions likely to be permanently disabling?

Yes, list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No

**4. 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.

## 6.10. DBQ Gulf War General Medical Examination

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. Definitions**

VA statutes and regulations provide for service connecting certain chronic disability patterns based on exposure

to environmental hazards experienced during military service in Southwest Asia. The environmental hazards may

have included: exposure to smoke and particles from oil well fires; exposure to pesticides and insecticides;

exposure to indigenous infectious diseases; exposure to solvent and fuel fumes; ingestion of pyridostigmine

bromide tablets, as a nerve gas antidote; the combined effect of multiple vaccines administered upon deployment;

and inhalation of ultra fine-grain sand particles. In addition, there may have been exposure to smoke and particles

from military installation “burn pit” fires that incinerated a wide range of toxic waste materials.

The chronic disability patterns associated with these Southwest Asia environmental hazards have two distinct

outcomes. One is referred to as “undiagnosed illnesses” and the other as “diagnosed medically unexplained chronic multisymptom illnesses**”. “**An undiagnosed illness is established when findings are present that cannot be attributed

to a known,clearly defined diagnosis, after all likely diagnostic possibilities for such abnormalities have been ruled

out.” Examples of medically unexplained chronic multi-symptom illnesses include, but are not limited to:

(1) chronic fatigue syndrome, (2) fibromyalgia, and (3) irritable bowel syndrome.Diseases of “partially explained

etiology,” such as diabetes or multiple sclerosis, are not considered by VA to be in the category of medically unexplained chronic multisymptom illnesses.

The following are signs or symptoms that may represent an “undiagnosed illness” or “diagnosed medically unexplained chronic multisymptom illness**”** for which a Gulf War Veteran will be presumptively service connected:

Fatigue

Signs or symptoms involving the skin

Headache

Muscle pain

Joint pain

Neurological signs and symptoms

Neuropsychological signs or symptoms

Upper or lower respiratory system signs or symptoms

Sleep disturbances

Gastrointestinal signs or symptoms

Cardiovascular signs or symptoms

Abnormal weight loss

Menstrual disorders

**2. Medical history**

2a. Perform a thorough review of all body systems. Based on this review, complete the sections below that pertain

to the Veteran’s symptoms. Complete the appropriate Questionnaire(s) based on your selections below.

a. Is there a skin and/or scar condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Skin Diseases

Scars

b. Is there a hemic and/or lymphatic condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Hematologic (including Anemia) and Lymphatic (Including Non-Hodgkin’s

Lymphoma)

Hairy Cell & Other B-Cell Leukemias

c. Is there an eye condition?  Yes  No

If yes, complete the Eyes Questionnaire.

Note:Vision evaluations must be conducted by a specialist.

d. Is there an ear condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Hearing Loss and Tinnitus

Ear Conditions

Note:Audio evaluations must be conducted by a specialist.

e. Is there a nose, sinuses, mouth and/or throat condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Sinusitis/Rhinitis and Other Conditions of the Nose, Throat, Larynx and

Pharynx

Loss of Sense of Smell and/or Taste

Oral and Dental Conditions (including mouth, lips and tongue)

Temporomandibular Joint

f. Is there a respiratory condition other than tuberculosis?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Respiratory Conditions (other than tuberculosis and sleep apnea)

Sleep Apnea

g. Is there a disorder of the breast?  Yes  No

If yes, complete the Breast Conditions & Disorders Questionnaire.

h. Is there a cardiovascular condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Ischemic Heart Disease

Artery & Vein Conditions (vascular diseases including varicose veins)

Hypertension

Heart Conditions (including arrhythmias, valvular disease, and cardiac surgery)

i. Is there an abdomen and/or digestive condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Esophageal Conditions (GERD and Hiatal Hernia)

Gallbladder and Pancreas

Infectious Intestinal Disorders (including bacterial and parasitic infections)

Intestinal Surgery (bowel resection, colostomy, and ileostomy)

Intestinal Conditions (other than Surgical and Infectious)

Hepatitis, Cirrhosis, and Other Liver Conditions

Peritoneal Adhesions

Stomach and Duodenal Conditions

Abdominal, Inguinal, and Femoral Hernias

Rectum and Anus (Including Hemorrhoids)

j. Is there a male genitourinary or reproductive system condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Kidney Conditions

Male Reproductive System

Prostate Cancer

Urinary Tract (including Bladder and Urethral) Conditions

k. Is there a female genitourinary or reproductive system condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Gynecological Conditions

Kidney Conditions

Urinary Tract (including Bladder and Urethral) Conditions

l. Is there a musculoskeletal condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Spine

Back (Thoracolumbar Spine) Conditions

Neck (Cervical Spine) Conditions

Joints and extremities

Ankle

Elbow and Forearm

Hands and Fingers

Hip and Thigh

Knee and Lower Leg

Shoulder and Arm Wrist

Feet

Flatfeet

Foot (other than Flatfeet)

Miscellaneous

Amputations

Fibromyalgia

Osteomyelitis

Muscle Injuries

Non-degenerative Arthritis (including inflammatory, autoimmune, crystalline and infectious arthritis)

and Dysbaric Osteonecrosis

m. Is there an endocrine and/or metabolic condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Diabetes Mellitus

Thyroid and Parathyroid

Endocrine Diseases (other than Thyroid, Parathyroid, or Diabetes Mellitus)

n. Is there a neurological condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Parkinson’s Disease

Amyotrophic Lateral Sclerosis (ALS)

Cranial Nerves Diseases

Diabetic Sensory-Motor Peripheral Neuropathy

Disease of the Central Nervous System

Fibromyalgia

Narcolepsy

Headaches (including Migraine Headaches)

Multiple Sclerosis (MS)

Peripheral Nerves

Seizure Disorders (Epilepsy)

Traumatic Brain Injury (Initial or Review)

NOTE: (The Initial and Review TBI Questionnaire can only be completed by a VA

clinician who has completed the TBI C&P certification. The initial diagnosis of TBI

must be made by a specialist, but a certified generalist can complete the

disability exam for TBI.)

o. Is there a psychiatric condition?  Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Eating Disorders

Mental Disorders (Other Than PTSD)

PTSD (Initial or Review)

Note:Mental evaluations must be conducted by a specialist.

p. Is there an infectious disease, an immune disorders and/or a nutritional deficiency? Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Chronic Fatigue Syndrome

Persian Gulf and Afghanistan Infectious Diseases

HIV and Related Illnesses

Infectious Diseases

Systemic Lupus Erythematosus and other Autoimmune Disorders

Nutritional Deficiencies

Tuberculosis

q. Does the Veteran have any conditions requiring the following additional Questionnaires?

Yes  No

If yes, check all that apply and complete the corresponding Questionnaire(s):

Cold Injury Residuals

Former Prisoner of War (POW) Protocol

2b. From the Questionnaires completed, are there any diagnosed illnesses for which no etiology was established?

Yes  No

If yes, complete the following for each:

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

ICD code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Questionnaire (DBQ): \_\_\_\_\_\_\_\_\_\_\_

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

ICD code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Questionnaire (DBQ): \_\_\_\_\_\_\_\_\_\_\_

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

ICD code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Questionnaire (DBQ): \_\_\_\_\_\_\_\_\_\_\_

If there are additional diagnoses, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2c. Does the Veteran report any additional signs and/or symptoms not addressed above?

Yes  No

If yes, check all that apply

Fatigue

Signs or symptoms involving the skin

Headache

Muscle pain

Joint pain

Neurological signs and symptoms

Neuropsychological signs or symptoms

Upper or lower respiratory system signs or symptoms

Sleep disturbances

Gastrointestinal signs or symptoms

Cardiovascular signs or symptoms

Abnormal weight loss

Menstrual disorders

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

2d. Provide all pertinent information related to each sign and/or symptom checked in question 2.c. (e.g. frequency, duration, severity, precipitating/relieving factors, physical exam, studies): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Functional impact**

Based on your examination and/or the Veteran’s history, do any of the signs and/or symptoms checked in question

2.c impact his or her ability to work?

Yes  No

If yes, for each sign and/or symptom that impacts his or her ability to work, describe impact, providing one or

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

**4. 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.

## 6.11. DBQ HIV-Related Illness

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 HIV or an HIV-related illness?

Yes  No

If yes, provide only diagnoses that pertain to HIV-related illnesses or complications:

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 HIV-related illness, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s HIV-related illness(es): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Is continuous medication required for control of HIV-related illness(es)?

Yes  No

If yes, list only those medications required for the Veteran’s HIV-related illness(es) (If the Veteran has more than

one HIV-related illness(es), specify the condition for which each medication is required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Does the Veteran have any complications due to current or previous medications taken for HIV-related

illness(es)?

Yes  No

If yes, list medication and describe complication(s) due to medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Signs, symptoms and findings**

Does the Veteran have any signs, symptoms or findings attributable to an HIV-related illness?

Yes  No

If yes, check all that apply:

a.  Constitutional symptoms (fever, weight loss, fatigue, malaise, decreased appetite, etc.) attributable

to an HIV-related illness

If checked, indicate frequency and severity:

Refractory  Recurrent

Describe constitutional symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b.  Diarrhea attributable to an HIV-related illness

If checked, indicate frequency and severity:

Refractory  Intermittent

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

c.  Weight loss attributable to an HIV-related illness

If checked, provide baseline weight: \_\_\_\_\_\_\_ and current weight: \_\_\_\_\_\_\_

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

d.  Nausea attributable to an HIV-related illness

If checked, indicate severity:

Mild  Transient  Recurrent  Periodic

Indicate frequency of episodes of nausea per year:

1  2  3  4 or more

e.  Vomiting attributable to an HIV-related illness

If checked, indicate severity:

Mild  Transient  Recurrent  Periodic

Indicate frequency of episodes of vomiting per year:

1  2  3  4 or more

Indicate average duration of episodes of vomiting:

Less than 1 day  1-9 days  10 days or more

f.  Anemia of chronic disease attributable to an HIV-related illness

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

Provide hemoglobin/hematocrit in Diagnostic testing section.

g.  Hairy cell leukoplakia

If checked, is Veteran currently affected by hairy cell leukoplakia?

Yes  No

Provide date(s) of onset, treatment and course: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

h.  Oral candidiasis

If checked, is Veteran currently affected by oral candidiasis?

Yes  No

Provide date(s) of onset, treatment and course: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

i.  Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Complications**

a. Does the Veteran have any complications attributable to an HIV-related illness or its treatment?

Yes  No

If yes, check all that apply:

HIV-associated neurocognitive disorder

If checked, a Mental Disorders Questionnaire must also be completed.

HIV-associated neuropathy, radiculopathy or myelopathy

If checked, a Peripheral Nerve Questionnaire must also be completed.

HIV-associated retinopathy

If checked, an Eye Questionnaire must also be completed.

HIV-associated cardiopathy

If checked, a Heart Questionnaire must also be completed.

HIV-associated pulmonary hypertension

If checked, a Respiratory Questionnaire must also be completed.

HIV-induced enteropathy

If checked, the appropriate gastrointestinal Questionnaire must also be completed.

HIV-associated nephropathy

If checked, a Kidney Questionnaire must also be completed.

HIV-associated impaired lipid and glucose metabolism

HIV-associated wasting

Lipodystrophy

Myopathy

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

b. For each checked condition (except those conditions for which an additional DBQ is completed), describe

(providing date of onset, and brief summary of symptoms, treatment and course): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Infectious and oncologic complications**

a. Does the Veteran now have or has he or she ever been had any HIV-related opportunistic infectious or oncologic conditions?

Yes  No

If yes, check all that apply:

Oral candidiasis

Tuberculosis

Hepatitis

Pneumocystosis

Toxoplasmosis

Cryptococcosis

Cerebral toxoplasmosis

Cryptococcal meningoencephalitis

Viral meningoencephalitis

Cytomegalovirus

Herpes simplex virus

Varicella zoster virus

Progressive multifocal leukoencephalopathy

Neurosyphilis

Primary central nervous system lymphoma

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

For each checked condition (except those conditions for which an additional DBQ is completed), describe

(providing date of onset, and brief summary of symptoms, treatment and course): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Does the Veteran have recurrent opportunistic infection(s)?

Yes  No

If yes, describe (providing types of infection(s), date(s) of onset, and brief summary of symptoms, treatment and

course):

ALSO complete the appropriate Questionnaire(s), if applicable.

**6. Mental health manifestations due to HIV-related illness or its treatment**

a. Does the Veteran have depression, cognitive impairment or dementia, or any other mental health conditions

attributable to HIV-related illness or its treatment?

Yes  No

b. Does the Veteran’s mental health condition(s), as identified in the question above, result in gross impairment in

thought processes or communication?

Yes  No

If No, also complete a Mental Disorder Questionnaire (schedule with appropriate provider).

If yes, briefly describe the Veteran’s mental health condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Summary**

Based on symptoms and findings from this exam, complete the following section to provide a summary of the

severity of the Veteran’s HIV-related condition. This summary provides useful information for VA purposes.

Select all that apply from each level:

a. Level I

Asymptomatic, with or without lymphadenopathy or decreased T4 cell count

b. Level II

Symptomatic, with current T4 cell of 200 or more and less than 500, and on approved medication(s)

(For VA purposes, approved medications include medications prescribed as part of a research protocol at

an accredited medical institution.)

Evidence of depression with employment limitations

Evidence of memory loss with employment limitations

c. Level III

Recurrent constitutional symptoms, intermittent diarrhea, and on approved medications

Current T4 cell count less than 200

Hairy cell leukoplakia

Oral candidiasis

d. Level IV

Refractory constitutional symptoms

Diarrhea and pathological weight loss

Development of AIDS-related opportunistic infection or neoplasm

e. Level V

AIDS with recurrent opportunistic infections

Secondary diseases afflicting multiple body systems

HIV-related illness with debility and progressive weight loss, without remission or few or brief remissions

**8. Other pertinent physical findings, scars, 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 related to any conditions listed in the Diagnosis section above?

Yes  No

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

**9. 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 tests are required for this

examination.

a. Has laboratory testing been performed?

Yes  No

If yes, check all that apply:

CD4 lymphocyte count: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Lowest (nadir) CD4 lymphocyte count, if available: \_\_\_\_\_\_\_\_\_\_\_\_ Date, if known: \_\_\_\_\_\_\_\_\_\_

CBC (if anemia of chronic disease attributable to HIV-related illness is suspected or present):

Date: \_\_\_\_\_\_\_\_\_ Hemoglobin: \_\_\_\_\_\_Hematocrit: \_\_\_\_\_\_\_ White blood cell count: \_\_\_\_\_\_ Platelets: \_\_\_\_\_

Other test, specify: \_\_\_\_\_\_ Date of test: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Have imaging studies or diagnostic procedures been performed and are the results available?

Yes  No

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

c. Has an HIV Dementia Scale been administered (if indicated)?

Yes  No

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. Has neuropsychiatric testing been performed for cognitive impairment (if indicated)?

Yes  No

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**

Do any of the Veteran’s HIV-related illnesses or complications impact his or her ability to work?

Yes  No

If yes, describe impact of each of the Veteran’s HIV-related illnesses, 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.

## 6.12. DBQ Infectious Diseases (other than HIV-related illness, chronic fatigue syndrome, and tuberculosis)

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 an infectious disease?

Yes  No

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

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

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

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

Leprosy (Hansen’s disease)

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

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

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

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

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

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

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

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

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

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

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

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

Parasitic Disease, NOSICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Other, specify:

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

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

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

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

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

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

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

NOTE: The diagnosis of malaria depends on the identification of the malarial parasites in blood smears. If the Veteran served in an endemic area and presents signs and symptoms compatible with malaria, the diagnosis may be based on clinical grounds alone. Relapses must be confirmed by the presence of malarial parasites in blood smears.

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s infectious disease condition(s): \_\_\_\_

b. Is continuous medication required for control of an infectious disease condition?

Yes  No

If yes, list only those medications required for the Veteran’s infectious disease condition (If the Veteran

has more than one infectious disease condition, specify the condition for which each medication is required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Status, symptoms, and residuals**

Complete the following section for each infectious disease condition:

Disease #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

a. Status of disease #1:

Active  Inactive

If inactive, date condition became inactive: \_\_\_\_\_\_\_\_\_\_\_\_\_

b. Does the Veteran have symptoms attributable to disease: #1?

Yes  No

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

c. Does the Veteran have residuals attributable to disease: #1?

Yes  No

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

If the Veteran has symptoms or residuals, ALSO complete the appropriate Questionnaire for each

symptomatic or residual condition (such as Skin, Heart, Peripheral or Central Nervous System,

Respiratory and appropriate Joint and Gastrointestinal Questionnaire).

Disease #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

a. Status of disease #2:

Active  Inactive

If inactive, date condition became inactive: \_\_\_\_\_\_\_\_\_\_\_\_\_

b. Does the Veteran have symptoms attributable to disease: #2?

Yes  No

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

c. Does the Veteran have residuals attributable to disease: #2?

Yes  No

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

If the Veteran has symptoms or residuals, ALSO complete the appropriate Questionnaire for each

symptomatic or residual condition (such as Skin, Heart, Peripheral or Central Nervous System,

Respiratory and appropriate Joint and Gastrointestinal Questionnaire).

Disease #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

a. Status of disease #3:

Active  Inactive

If inactive, date condition became inactive: \_\_\_\_\_\_\_\_\_\_\_\_\_

b. Does the Veteran have symptoms attributable to disease: #3?

Yes  No

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

c. Does the Veteran have residuals attributable to disease: #3?

Yes  No

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

If the Veteran has symptoms or residuals, ALSO complete the appropriate Questionnaire for each

symptomatic or residual condition (such as Skin, Heart, Peripheral or Central Nervous System,

Respiratory and appropriate Joint and Gastrointestinal Questionnaire).

If the Veteran has any additional infectious disease conditions, list and describe using above format: \_\_\_\_

**4. Other pertinent physical findings, scars, 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 related to any conditions listed in the Diagnosis section above?

Yes  No

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

**5. Diagnostic testing**

NOTE: If 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Functional impact**

Does the Veteran’s infectious disease condition(s) impact his or her ability to work?

Yes  No

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

**7. 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.

## 6.13. DBQ Initial Evaluation of Residuals of Traumatic Brain Injury(I-TBI) Disability

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.**

**SECTION I**

**1. Diagnosis**

Does the Veteran now have or has he/she ever had a traumatic brain injury (TBI) or any residuals of a TBI?

Yes  No

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

Traumatic brain injury (TBI) ICD code: \_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_

Other diagnosed residuals attributable to TBI, 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other diagnosis #4: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

If there are additional diagnoses that pertain to the residuals of a TBI, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s TBI and residuals attributable to TBI (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Was the Veteran exposed to any blasts?

Yes  No

If yes, indicate number of blasts:

1  2  3  More than 3

Date of first blast exposure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last blast exposure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many blasts were severe enough to knock Veteran down or cause injury?

0  1  2  3  More than 3

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

Yes  No

If yes, list only those medications used for the diagnosed condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Evidence review**

Was medical evidence available for review as part of this examination?

Yes  No

If yes, indicate evidence reviewed as part of this examination (check all that apply):

VA claims file (C-file)

If checked, documents listed separately below that are included in a C-file do not need to be additionally

indicated.

Veterans Health Administration medical records (CPRS treatment records)

Civilian medical records

Military service treatment records

Military service personnel records

Military enlistment examination

Military separation examination

Military post-deployment questionnaire

Department of Defense Form 214 separation document

Previous disability decision letters

Correspondence and non-medical documents related to condition

Interviews with collateral witnesses (family and others who have known the Veteran before and after military service)

Medical evidence brought to exam by Veteran

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

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

**SECTION II. Assessment of cognitive impairment and other residuals of TBI**

NOTE: For each of the following 10 facets of TBI-related cognitive impairment and subjective symptoms (facets 1-10 below), select the ONE answer that best represents the Veteran’s current functional status.

Neuropsychological testing may need to be performed in order to be able to accurately complete this section. If neuropsychological testing has been performed and accurately reflects the Veteran’s current functional status, repeat testing is not required.

**1. Memory, attention, concentration, executive functions**

No complaints of impairment of memory, attention, concentration, or executive functions

A complaint of mild memory loss (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing

Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment

Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment

Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment

If the Veteran has complaints of impairment of memory, attention, concentration or executive functions, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Judgment**

Normal

Mildly impaired judgment. For complex or unfamiliar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision

Moderately impaired judgment. For complex or unfamiliar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, although has little difficulty with simple decisions

Moderately severely impaired judgment. For even routine and familiar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision

Severely impaired judgment. For even routine and familiar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision. For example, unable to determine appropriate clothing for current weather conditions or judge when to avoid dangerous situations or activities.

If the Veteran has impaired judgment, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Social interaction**

Social interaction is routinely appropriate

Social interaction is occasionally inappropriate

Social interaction is frequently inappropriate

Social interaction is inappropriate most or all of the time

If the Veteran’s social interaction is not routinely appropriate, describe (brief summary): \_\_\_\_\_\_\_\_

**4. Orientation**

Always oriented to person, time, place, and situation

Occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation

Occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation

Often disoriented to two or more of the four aspects (person, time, place, situation) of orientation

Consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation

If the Veteran is not always oriented to person, time, place, and situation, describe (brief summary): \_\_

**5. Motor activity (with intact motor and sensory system)**

Motor activity normal

Motor activity is normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function)

Motor activity is mildly decreased or with moderate slowing due to apraxia

Motor activity moderately decreased due to apraxia

Motor activity severely decreased due to apraxia

If the Veteran has any abnormal motor activity, describe (brief summary): \_\_\_\_\_\_

**6. Visual spatial orientation**

Normal

Mildly impaired. Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system)

Moderately impaired. Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS (global positioning system)

Moderately severely impaired. Gets lost even in familiar surroundings, unable to use assistive devices such as GPS (global positioning system)

Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment

If the Veteran has impaired visual spatial orientation, describe (brief summary): \_\_\_\_\_\_\_\_\_\_

**7. Subjective symptoms**

No subjective symptoms

Subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples are: mild or occasional headaches, mild anxiety

Three or more subjective symptoms that mildly interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light

Three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days

If the Veteran has subjective symptoms, describe (brief summary): \_\_\_\_\_\_

**8. Neurobehavioral effects**

NOTE: Examples of neurobehavioral effects of TBI include: irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, belligerence, apathy, lack of empathy, moodiness, and lack of cooperation, inflexibility, and impaired awareness of disability. Any of these effects may range from slight to severe, although verbal and physical aggression are likely to have a more serious impact on workplace interaction and social interaction than some of the other effects.

No neurobehavioral effects

One or more neurobehavioral effects that do not interfere with workplace interaction or social interaction.

One or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them

One or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them

One or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction, or both on most days or that occasionally require supervision for safety of self or others

If the Veteran has any neurobehavioral effects, describe (brief summary): \_\_\_\_\_\_

**9. Communication**

Able to communicate by spoken and written language (expressive communication) and to comprehend spoken and written language.

Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas.

Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than occasionally but less than half of the time. Can generally communicate complex ideas

Inability to communicate either by spoken language, written language, or both, at least half of the time but not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs

Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both. Unable to communicate basic needs

If the Veteran is not able to communicate by or comprehend spoken or written language, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. Consciousness**

Normal

Persistent altered state of consciousness, such as vegetative state, minimally responsive state, coma.

If checked, describe altered state of consciousness (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION III**

**1. Residuals**

Does the Veteran have any subjective symptoms or any mental, physical or neurological conditions or residuals attributable to a TBI (such as migraine headaches or Meniere’s disease)?

Yes  No

If yes, check all that apply:

Motor dysfunction

If checked, ALSO complete specific Joint or Spine Questionnaire for the affected joint or spinal area.

Sensory dysfunction

If checked, ALSO complete appropriate Cranial or Peripheral Nerve Questionnaire.

Hearing loss and/or tinnitus

If checked, ALSO complete a Hearing Loss and Tinnitus Questionnaire.

Visual impairment

If checked, ALSO complete an Eye Questionnaire.

Alteration of sense of smell or taste

If checked, ALSO complete a Loss of Sense of Smell and Taste Questionnaire.

Seizures

If checked, ALSO complete a Seizure Disorder Questionnaire.

Gait, coordination, and balance

If checked, ALSO complete appropriate Questionnaire for underlying cause of gait and balance disturbance, such as Ear Questionnaire.

Speech (including aphasia and dysarthria)

If checked, ALSO complete appropriate Questionnaire.

Neurogenic bladder

If checked, ALSO complete appropriate Genitourinary Questionnaire.

Neurogenic bowel

If checked, ALSO complete appropriate Intestines Questionnaire.

Cranial nerve dysfunction

If checked, ALSO complete a Cranial Nerves Questionnaire.

Skin disorders

If checked, ALSO complete a Skin and/or Scars Questionnaire.

Endocrine dysfunction

If checked, ALSO complete an Endocrine Conditions Questionnaire.

Erectile dysfunction

If checked, ALSO complete Male Reproductive Conditions Questionnaire.

Headaches, including Migraine headaches

If checked, ALSO complete a Headache Questionnaire.

Meniere’s disease

If checked, ALSO complete an Ear Conditions Questionnaire.

Mental disorder (including emotional, behavioral, or cognitive)

If checked, ALSO complete Mental Disorders or PTSD Questionnaire.

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

If checked, ALSO complete appropriate Questionnaire.

**2. Other pertinent physical findings, scars, 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Diagnostic testing**

NOTE: If diagnostic test results are in the medical record and reflect the Veteran’s current TBI residuals, repeat

testing is not required.

a. Has neuropsychological testing been performed?

Yes  No

If yes, provide date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Have diagnostic imaging studies or other diagnostic procedures been performed?

Yes  No

If yes, check all that apply:

Magnetic resonance imaging (MRI)

Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Computed tomography (CT)

Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

EEG

Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Has laboratory testing been performed?

Yes  No

If yes, specify tests: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Functional impact**

Do any of the Veteran’s residual conditions attributable to a traumatic brain injury impact his or her ability to work?

Yes  No

If yes, describe impact of each of the Veteran’s residual conditions attributable to a traumatic brain injury, providing one or more examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. 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.

## 6.14. DBQ Loss of Sense of Smell and or Taste

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

**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 loss of sense of smell or taste?

Yes  No

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

Anosmia (inability to detect any odor) ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Hyposmia (reduced ability to detect odors) ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Ageusia (complete lack of taste) ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Hypogeusia (decrease in sense of taste) ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Other, specify:

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

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

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

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

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

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

If there are additional diagnoses that pertain to complete loss of sense of smell or taste, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical history**

Describe the history (including onset and course) of the Veteran’s loss of sense of smell or taste (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Symptoms**

a. Does the Veteran currently have loss of sense of smell?

Yes  No

If yes, indicate severity:

Partial

Complete

If yes, is there a known anatomical or pathological basis for this condition?

Yes  No

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

b. Does the Veteran currently have loss of sense of taste (unable to detect sweet, salty, sour, or bitter tastes)?

Yes  No

If yes, indicate severity:

Partial

Complete

If yes, is there a known anatomical or pathological basis for this condition?

Yes  No

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

**4. Other pertinent physical findings, scars, 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

related to any conditions listed in the Diagnosis section above?

Yes  No

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

**5. Diagnostic testing**

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

is not required.

a. Have imaging or laboratory studies been performed?

Yes  No

If yes, check all that apply:

Magnetic resonance imaging (MRI) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_

Computed tomography (CT) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_

b. Has qualitative smell testing been performed?

Yes  No

If yes, complete the following:

Type of test: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_

c. 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Functional impact**

Does the Veteran’s loss of sense of smell or taste impact on his or her ability to work?

Yes  No

If yes, describe the impact of each of the Veteran’s conditions related to the loss of sense of smell or taste,

providing one or more examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. 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.

## 6.15. DBQ Narcolepsy

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 have or has he/she ever been diagnosed with narcolepsy?

Yes  No

If yes, check the appropriate diagnoses (check all that apply):

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

Other, specify:

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

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

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

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

NOTE: If other respiratory condition is diagnosed, complete the Respiratory and/or Sleep Apnea

Questionnaire(s), in lieu of this one.

**2. Medical history**

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

b. Is continuous medication required for control of narcolepsy?

Yes  No

If yes, list only those medications required for the Veteran’s narcolepsy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Findings, signs and symptoms**

Does the Veteran have a confirmed diagnosis of narcolepsy with a history of narcoleptic episodes?

Yes  No

If yes, complete the following:

a. If yes, does the Veteran report any of the following findings, signs or symptoms?

Yes  No

If yes, check all that apply:

Excessive daytime sleepiness

Sleep attacks (strong urge to sleep, followed by short nap)

Cataplexy (sudden loss of muscle tone while awake, resulting in brief inability to move)

Sleep paralysis (inability to move on first awakening)

Hallucinations

For all checked conditions or for any other conditions, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Indicate frequency of narcoleptic episodes (check all that apply):

Number of narcoleptic episodes over past 6 months:

0-1

2 or more

If 2 or more over the past 6 months, indicate the average frequency of narcoleptic episodes:

0-4 per week

5-8 per week

9-10 per week

More than 10 per week

If the Veteran has narcoleptic episodes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. 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 (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Diagnostic testing**

NOTE: If diagnostic test results are in the medical record and reflect the Veteran’s current narcolepsy

condition, repeat testing is not required.

a. Have any imaging studies or diagnostic procedures been performed?

Yes  No

If yes, check all that apply:

Polysomnogram (PSG) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Multiple Sleep Latency Test (MSLT) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hypocretin level in cerebrospinal fluid (CSF) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Functional impact**

Does the Veteran’s narcolepsy impact his or her ability to work?

Yes  No

If yes, describe impact, providing one or more examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. 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.

## 6.16. DBQ Nutritional Deficiencies

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 nutritional deficiency?

Yes  No

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

Avitaminosis

Beriberi (Vitamin B1 or thiamine deficiency)

Pellegra (Vitamin B3 or niacin deficiency)

Other nutritional deficiency condition:

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

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

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

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

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

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

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

For all identified complications or residual conditions, ALSO complete additional Questionnaires

as appropriate (such as skin, heart, peripheral nerves, etc.)

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s nutritional deficiency conditions

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

b. Does the Veteran’s nutritional deficiency condition require continuous medications for control?

Yes  No

If yes, list medications used for nutritional deficiency conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Findings, signs and symptoms**

a. Does the Veteran have any findings, signs or symptoms attributable to pellagra or avitaminosis?

Yes  No

If yes, indicate the choice that best describes the current severity:

Confirmed diagnosis with nonspecific symptoms such as decreased appetite, weight loss,

abdominal discomfort, weakness, inability to concentrate and irritability

With stomatitis or achlorhydria or diarrhea

With stomatitis, diarrhea, and symmetrical dermatitis

With all of the symptoms listed above plus mental symptoms and impaired bodily vigor

Marked mental changes, moist dermatitis, inability to retain nourishment, exhaustion, and cachexia

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

b. Does the Veteran have any findings, signs or symptoms attributable to active beriberi?

Yes  No

If yes, indicate the choice that best describes the current severity:

Peripheral neuropathy with absent knee or ankle jerks and loss of sensation

Symptoms such as weakness, fatigue, anorexia, dizziness, heaviness and stiffness of legs, headache,

or sleep disturbance

Cardiomegaly

Peripheral neuropathy with foot drop or atrophy of thigh or calf muscles

Congestive heart failure, anasarca, or Wernicke-Korsakoff syndrome

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

c. Does the Veteran have any findings, signs or symptoms attributable to residuals of beriberi?

Yes  No

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

d. Does the Veteran have any findings, signs or symptoms attributable to conditions or residuals

caused by any other vitamin deficiency?

Yes  No

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

For all checked answers for questions a-d, ALSO complete additional Questionnaires as

appropriate (such as Mental Disorders, Skin, Heart, Peripheral Nerves, etc.)

**4. Other pertinent physical findings, scars, 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 related to any conditions listed in the Diagnosis section above?

Yes  No

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

**5. Diagnostic testing**

NOTE: If testing has been completed and reflects Veteran’s current condition, further testing is not required.

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

Yes  No

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

**6. Functional impact**

Does the Veteran’s nutritional deficiency condition(s) impact his or her ability to work?

Yes  No

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

**7. 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.

## 6.17. DBQ Oral and Dental Conditions including Mouth, Lips and Tongue

## (other than Temporomandibular Joint 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/she ever been diagnosed with an oral or dental condition?

Yes  No

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

Loss of any portion of mandible ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Loss of any portion of maxilla ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Malunion or nonunion of mandible ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Malunion or nonunion of maxilla ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Loss of teeth (for reasons other than periodontal disease)

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

Temporomandibular joint disorder (TMJD)

If checked, complete the Temporomandibular Joint Questionnaire in lieu of this Questionnaire if that is the

Veteran’s only condition. If the Veteran has a TMJ condition AND additional oral or dental conditions, complete this Questionnaire and ALSO complete the Temporomandibular Joint Questionnaire.

Limitation of motion of the temporomandibular joint due to causes other than temporomandibular joint disorder

If checked, complete this Questionnaire and ALSO complete the Temporomandibular Joint Questionnaire.

Anatomical loss or injury of the mouth, lips or tongue

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

Osteomyelitis or osteoradionecrosis of the mandible

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

Oral neoplasm

If checked, specify: \_\_\_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_

Periodontal disease

If this is the ONLY diagnosis checked, proceed to the signature section at the end of this form (for VA purposes

this disease is not considered disabling)

Other, specify:

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

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

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

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

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

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

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

NOTE: This Questionnaire is appropriate for bone loss due to trauma or disease such as osteomyelitis and

not to the loss of the alveolar process as a result of periodontal disease, since such loss is not considered

disabling.

**2. Medical History**

a. Describe the history (including onset and course) of the Veteran’s oral and/or dental condition: \_\_\_\_\_\_

b. Is continuous medication required for control of an oral or dental condition?

Yes  No

If yes, list only those medications required for the Veteran’s oral or dental conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Mandible**

Does the Veteran have any anatomical loss or bony injury of the mandible?

Yes  No

If yes, complete the following section:

a. Has the veteran lost any part of the mandible or mandibular ramus?

Yes  No

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

Loss of approximately 1/2 of the mandible, not involving the temporomandibular articulation

Loss of approximately 1/2 of the mandible, involving the temporomandibular articulation

Complete loss of the mandible between angles

Loss of less than 1/2 the substance of mandibular ramus, not involving loss of continuity

If checked, indicate side:  Right  Left  Both

Loss of whole or part of mandibular ramus, without loss of temporomandibular articulation

If checked, indicate side:  Right  Left  Both

Loss of whole or part of mandibular ramus, involving loss of temporomandibular articulation

If checked, indicate side:  Right  Left  Both

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

b. Has the Veteran lost either condyloid process of the mandible?

Yes  No

If yes, indicate side:  Right  Left  Both

c. Has the Veteran lost either coronoid process of the mandible?

Yes  No

If yes, indicate side:  Right  Left  Both

d. Has the Veteran had an injury resulting in malunion or nonunion of the mandible?

Yes  No

If yes, indicate severity:

Malunion with slight displacement

Malunion with moderate displacement

Malunion with severe displacement

Nonunion, moderate

Nonunion, severe

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

NOTE: The assessment of the severity of malunion or nonunion of the mandible is dependent upon degree of

motion and relative loss of masticatory function.

**4. Maxilla**

Does the Veteran have any anatomical loss or bony injury of the maxilla?

Yes  No

If yes, complete the following section:

a. Has the Veteran lost any part of the maxilla?

Yes  No

If yes, indicate the severity:

Loss of less than 25%

Loss of 25 to 50%

Loss of more than 50%

b. If the Veteran has lost any part of the maxilla, is the loss replaceable by prosthesis?

Yes  No  Not applicable

c. Has the Veteran lost any part of the hard palate?

Yes  No

If yes, indicate the severity:

Loss of less than 50%

Loss of 50% or more

d. If the Veteran has lost any part of the hard palate, is the loss replaceable by prosthesis?

Yes  No  Not applicable

e. Has the Veteran had an injury resulting in malunion or nonunion of the maxilla?

Yes  No

If yes, indicate severity:

Malunion or nonunion with slight displacement

Malunion or nonunion with moderate displacement

Malunion or nonunion with severe displacement

**5. Teeth**

Does the Veteran have anatomical loss or bony injury of any teeth (other than that due to the loss of the

alveolar process as a result of periodontal disease)?

Yes  No

If yes, complete the following section:

a. Is the loss of teeth due to loss of substance of body of maxilla or mandible without loss of continuity?

Yes  No

b. Is the loss of teeth due to trauma or disease (such as osteomyelitis)?

Yes  No

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

c. Can the masticatory surfaces be restored by suitable prosthesis?

Yes  No

d. Indicate the extent of loss of teeth from the selections below (check all that apply):

All upper teeth

All lower teeth

All upper and lower posterior teeth (both right and left)

All upper and lower anterior teeth (both right and left)

All upper anterior teeth (both right and left)

All lower anterior teeth (both right and left)

All right upper and lower teeth

All left upper and lower teeth

None of the above

**6. Mouth, lips, tongue and disfiguring scars**

Does the Veteran have anatomical loss or injury of the mouth, lips or tongue?

Yes  No

If yes, complete the following section:

a. Does the Veteran have any disfiguring scars to the mouth or lips?

Yes  No

If yes, ALSO complete a Scars Questionnaire.

b. Does the Veteran have a mouth injury that results in impairment of mastication?

Yes  No

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

c. Does the Veteran have partial or complete loss of the tongue?

Yes  No

If yes, indicate severity:

Loss of less than 1/2 of tongue

Loss of 1/2 or more of tongue

d. Does the Veteran have a speech impairment caused by partial or complete loss of the tongue, or by any

other tongue condition?

Yes  No

If yes, indicate severity:

Marked speech impairment

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

Inability to communicate by speech

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

**7. Osteomyelitis/osteoradionecrosis**

Does the Veteran now have or has he or she ever been diagnosed with osteomyelitis or osteoradionecrosis of

the mandible?

Yes  No

If yes, ALSO complete Osteomyelitis Questionnaire.

**8. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

a. Does the Veteran have any scars (surgical or otherwise)(other than those referred to in question 6) 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 related to any conditions listed in the Diagnosis section above?

Yes  No

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

**10. Diagnostic testing**

NOTE: If diagnostic test results are in the medical record and reflect the Veteran’s current oral or dental

condition, repeat testing is not required.

a. Have imaging studies or procedures been performed?

Yes  No

If yes, check all that apply:

Panographic dental x-ray to demonstrate loss of teeth, mandible or maxilla Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other x-rays Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Magnetic resonance imaging (MRI) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Computed tomography (CT) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**

Does the Veteran’s oral or dental condition impact his or her ability to work?

Yes  No

If yes, describe impact of each of the Veteran’s oral or dental 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.

## 6.18. DBQ Respiratory Conditions (other than Tuberculosis and Sleep Anpea)

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.

**SECTION I: DIAGNOSES**

**NOTE: The diagnosis section should be filled out AFTER the clinician has completed the evaluation.**

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

Yes  No

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

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

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

Chronic obstructive pulmonary disease (COPD)

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

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

Interstitial lung disease

If checked, specify: \_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

(Interstitial lung diseases include but are not limited to asbestosis, diffuse interstitial fibrosis, interstitial pneumonitis, fibrosing alveolitis, desquamative interstitial pneumonitis, pulmonary alveolar proteinosis,

eosinophilic granuloma of lung, drug-induced pulmonary pneumonitis and fibrosis, radiation-induced

pulmonary pneumonitis and fibrosis, hypersensitivity pneumonitis (extrinsic allergic alveolitis) and

pneumoconiosis such as silicosis, anthracosis, etc.)

Restrictive lung disease

If checked, specify: \_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

(Restrictive lung diseases include but are not limited to diaphragm paralysis or paresis, spinal cord injury

with respiratory insufficiency, kyphoscoliosis, pectus excavatum, pectus carinatum, traumatic chest wall

defect, pneumothorax, hernia, etc., post-surgical residual (lobectomy, pneumonectomy, etc.), chronic pleural effusion or fibrosis)

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

Benign or malignant neoplasm or metastases of respiratory system

If checked, specify: \_\_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Pulmonary vascular disease (including pulmonary thromboembolism)

If checked, specify: \_\_\_\_\_\_\_\_ ICD code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

NOTE: If diagnosed with Sleep Apnea and/or Narcolepsy complete the Sleep Apnea and/or Narcolepsy

Questionnaire(s), in lieu of this one.

**SECTION II: MEDICAL HISTORY**

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

b. Does the Veteran’s respiratory condition require the use of oral or parenteral corticosteroid medications?

Yes  No

If yes, complete the following:

Requires chronic low dose (maintenance) corticosteroids

Requires intermittent courses or bursts of systemic (oral or parenteral) corticosteroids

If checked, indicate number of courses or bursts in past 12 months:

0  1  2  3  4 or more

Requires systemic (oral or parenteral) high dose (therapeutic) corticosteroids for control

Requires daily use of systemic (oral or parenteral) high dose corticosteroids or immuno-suppressive

medications

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

If the Veteran has more than one respiratory condition, indicate the condition which is predominantly responsible

for the need for corticosteroids or immuno-suppressive medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Does the Veteran’s respiratory condition require the use of inhaled medications?

Yes  No

If yes, check all that apply:

Inhalational bronchodilator therapy

If checked, indicate frequency:  Intermittent  Daily

Inhalational anti-inflammatory medication

If checked, indicate frequency:  Intermittent  Daily

Other inhaled medications, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the Veteran has more than one respiratory condition, indicate the condition which is predominantly responsible

for the need for inhaled medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. Does the Veteran’s respiratory condition require the use of oral bronchodilators?

Yes  No

If yes, indicate frequency:

Intermittent  Daily

e. Does the Veteran’s respiratory condition require the use of antibiotics?

Yes  No

If yes, list antibiotics, dose, frequency and condition for which antibiotics are prescribed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

f. Does the Veteran require outpatient oxygen therapy for his or her respiratory condition?

Yes  No

If yes, does the Veteran require continuous oxygen therapy (>17 hours/day)?

Yes  No

If the Veteran has more than one respiratory condition, indicate the condition which is predominantly responsible

for the requirement for oxygen therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION III: Pulmonary conditions**

Does the Veteran have any of the following pulmonary conditions?

Yes  No

If no, proceed to Section V.

If yes, check all that apply:

Asthma (If checked, complete # 1 below)

Bronchiectasis (If checked, complete # 2 below)

Sarcoidosis (If checked, complete # 3 below)

Pulmonary vascular disease including pulmonary embolism

(If checked, complete # 4 below)

Bacterial lung infection (If checked, complete # 5 below)

Mycotic lung infection (If checked, complete # 6 below)

Pneumothorax (If checked, complete # 7 below)

Gunshot/fragment wound (If checked, complete # 8 below)

Cardiopulmonary complications (If checked, complete # 9 below)

Respiratory failure (If checked, complete # 10 below)

Tumors and neoplasms (If checked, complete # 11 below)

Other pulmonary conditions, pertinent physical findings or scars due to pulmonary conditions (If checked, complete # 12 below)

**1. Asthma**

a. Does the Veteran have a history of asthmatic attacks?

Yes  No

b. Has the Veteran had any asthma attacks or exacerbations in the past 12 months?

Yes  No

If yes, check all that apply:

No asthma attacks in the past 12 months

No asthma exacerbations in the past 12 months

Physician visits for required care of exacerbations

If checked, indicate frequency:

Less frequently than monthly  At least monthly

More than one attack per week

If checked, indicate average number of asthma attacks per week in past 12 months:

0  1  2  3  4 or more

Episodes of respiratory failure

If checked, indicate number of episodes of respiratory failure due to asthma in past 12 months:

0  1  2  3  4 or more

c. Has the Veteran had any physician visits for required care of exacerbations?

Yes  No

If yes, indicate frequency:

Less frequently than monthly

At least monthly

d. Has the Veteran had any episodes of respiratory failure?

Yes  No

If yes, indicate number of episodes of respiratory failure in past 12 months:

0  1  2  3  4 or more

**2. Bronchiectasis**

a. Indicate any findings, signs and symptoms that are attributable to bronchiectasis:

Productive cough

If checked, indicate frequency and severity of productive cough (check all that apply):  
 Intermittent

Daily with purulent sputum at times

Daily with blood-tinged sputum at times

Near constant with purulent sputum

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

Acute infection

If checked, indicate number of infections requiring a prolonged course of antibiotics (lasting 4 to 6 weeks)

in the past 12 months

0  1  2  3  4 or more

Requiring antibiotic usage almost continuously

Anorexia

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

Weight loss

If checked, provide baseline weight: \_\_\_\_\_\_\_ and current weight: \_\_\_\_\_\_\_

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

Frank hemoptysis

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

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

b. Has the Veteran had any incapacitating episodes of infection due to bronchiectasis?

NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require

prescribed bed rest and treatment by a physician.

Yes  No

If yes, indicate total duration of incapacitating episodes of infection in past 12 months:

0 to no more than 2 weeks  2 to no more than 4 weeks

4 to no more than 6 weeks  At least 6 weeks or more

**3. Sarcoidosis**

a. Does the Veteran have any findings, signs or symptoms attributable to sarcoidosis?

Yes  No

If yes, check all that apply:

No physiologic impairment

No symptoms

Persistent symptoms

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

Chronic hilar adenopathy

Stable lung infiltrates

Pulmonary involvement

Progressive pulmonary disease

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

Cardiac involvement with congestive heart failure

Fever

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

Night sweats

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

Weight loss

If checked, provide baseline weight: \_\_\_\_\_\_\_ and current weight: \_\_\_\_\_\_\_

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

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

b. Indicate stage diagnosed by x-ray findings:

Stage 1: Bihilar lymphadenopathy

Stage 2: Bihilar lymphadenopathy and reticulonodular infiltrates

Stage 3: Bilateral pulmonary infiltrates

Stage 4: Fibrocystic sarcoidosis typically with upward hilar retraction, cystic and bullous changes

c. Does the Veteran have ophthalmologic, renal, cardiac, neurologic, or other organ system involvement due to sarcoidosis?

Yes  No

If yes, also complete appropriate additional Questionnaires.

**4. Pulmonary vascular disease including pulmonary embolism**

Select the statement(s) that best describe the Veteran’s pulmonary vascular disease or pulmonary embolism

condition (check all that apply):

Asymptomatic, following resolution of pulmonary thromboembolism

Symptomatic, following resolution of acute pulmonary embolism

Chronic pulmonary thromboembolism requiring anticoagulant therapy

Following inferior vena cava surgery

Chronic pulmonary thromboembolism

Pulmonary hypertension secondary to other obstructive disease of pulmonary arteries or veins with

evidence of right ventricular hypertrophy or cor pulmonale

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

**5. Bacterial lung infection**

a. Indicate current status of the Veteran’s bacterial infection of the lung (including actinomycosis, nocardiosis and

chronic lung abscess):

Active  Inactive

b. Does the Veteran have any findings, signs and symptoms attributable to a bacterial infection of the lung or chronic

lung abscess?

Yes  No

If yes, check all that apply:

Fever

Night sweats

Weight loss

If checked, provide baseline weight: \_\_\_\_\_\_\_ and current weight: \_\_\_\_\_\_\_

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

Hemoptysis

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

**6. Mycotic lung diseases**

Indicate status of mycotic lung disease (including histoplasmosis of lung, coccidioidomycosis, blastomycosis, cryptococcosis, aspergillosis, or mucormycosis) (check all that apply):

Chronic pulmonary mycosis

Healed and inactive mycotic lesions

No symptoms

Occasional productive cough

Occasional minor hemoptysis

Requires suppressive therapy

Fever

Night sweats

Weight loss

If checked, provide baseline weight: \_\_\_\_\_\_\_ and current weight: \_\_\_\_\_\_\_

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

Massive hemoptysis

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

**7. Pneumothorax**

Indicate the type of pneumothorax, treatment and residual conditions, if any (check all that apply):

Spontaneous total pneumothorax

Spontaneous partial pneumothorax

Traumatic total pneumothorax

Traumatic partial pneumothorax

Resulting in hospitalization

If checked, provide date of hospital admission\_\_\_\_\_\_\_\_\_\_ and date of discharge:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resulting in residual conditions

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

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

**8. Gunshot/fragment wound**

Select the statement(s) that best describe the Veteran’s gunshot or fragment wound of the pleural cavity and

residuals, if any (check all that apply)

Bullet or missile retained in lung

Pain or discomfort on exertion

Scattered rales

Some limitation of excursion of diaphragm or of lower chest expansion

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

NOTE: If any muscles (other than those which control respiration) are affected by this injury, also complete a

Muscle Injuries Questionnaire**.**

**9. Cardiopulmonary complications**

a. Does the Veteran’s respiratory condition result in cardiopulmonary complications such as cor pulmonale,

right ventricular hypertrophy or pulmonary hypertension?

Yes  No

If yes, check all that apply:

Cor pulmonale (right heart failure)

Right ventricular hypertrophy

Pulmonary hypertension (shown by echocardiogram or cardiac catheterization; report test results

in Diagnostic testing section)

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

b. If the Veteran has more than one respiratory condition, indicate which condition is predominantly responsible

for the cardiopulmonary complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. Respiratory failure**

Provide dates and describe the Veteran’s episodes of acute respiratory failure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the Veteran has more than one respiratory condition, indicate which condition is predominantly responsible for the episodes of respiratory failure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11. 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 (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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12. Other pertinent physical findings, scars, 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 related to any conditions listed in the Diagnosis section above?

Yes  No

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

**SECTION IV: Diagnostic testing**

NOTE: If diagnostic test results are in the medical record and reflect the Veteran’s current respiratory

condition, repeat testing is not required.

a. Have imaging studies or procedures been performed?

Yes  No

If yes, check all that apply:

Chest x-ray Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Magnetic resonance imaging (MRI) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Computed tomography (CT) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

High resolution computed tomography to evaluate interstitial lung disease such as asbestosis (HRCT) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bronchoscopy Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Biopsy Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Has pulmonary function testing (PFT) been performed?

Yes  No

If yes, do PFT results reported below reflect the Veteran’s current pulmonary function?

Yes  No

c. Most respiratory conditions will require pulmonary function testing, since the results of such testing represent

a major basis of their evaluation. However, pulmonary function testing is not required in all instances. If PFTs

have not been completed, provide reason:

Veteran requires outpatient oxygen therapy

Veteran has had 1 or more episodes of acute respiratory failure

Veteran has been diagnosed with cor pulmonale, right ventricular hypertrophy or pulmonary hypertension

Veteran has had exercise capacity testing and results are 20 ml/kg/min or less

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

d. PFT results

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

Pre-bronchodilator: Post-bronchodilator, if indicated:

FEV-1: \_\_\_\_\_\_\_\_% predicted FEV-1: \_\_\_\_\_\_\_\_% predicted

FVC: \_\_\_\_\_\_\_\_% predicted FVC: \_\_\_\_\_\_\_\_ % predicted

FEV-1/FVC: \_\_\_\_\_\_\_\_ % FEV-1/FVC: \_\_\_\_\_\_\_\_ %

DLCO: \_\_\_\_\_\_\_\_% predicted DLCO: \_\_\_\_\_\_\_\_ % predicted

e. Which test result most accurately reflects the Veteran’s current pulmonary function?

FEV-1%

FEV-1/FVC%

FVC%

DLCO

f. If post-bronchodilator testing has not been completed, provide reason:

Pre-bronchodilator results are normal

Not indicated for Veteran’s condition

Not indicated in Veteran’s particular case

If checked, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

g. If diffusion capacity of the lung for carbon monoxide by the single breath method (DLCO) testing has not been completed, provide reason:

Not indicated for Veteran’s condition

Not indicated in Veteran’s particular case

Not valid for Veteran’s particular case

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

h. Does the Veteran have multiple respiratory conditions?

Yes  No

If yes, list conditions and indicate which condition is predominantly responsible for the limitation in pulmonary

function, if any limitation is present: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

i. Has exercise capacity testing been performed?

Yes  No

If yes, complete the following:

Maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation)

Maximum oxygen consumption of 15–20 ml/kg/min (with cardiorespiratory limit)

j. 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION V: Functional impact and remarks**

**1**.Does the Veteran’s respiratory condition impact his or her ability to work?

Yes  No

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

**2. 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.

## 6.19. DBQ Review Evaluation of Residuals of Traumatic Brain Injury(R-TBI)

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.**

**SECTION I**

**1. Diagnosis**

Does the Veteran now have or has he/she ever had a traumatic brain injury (TBI) or any residuals of a TBI?

Yes  No

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

Traumatic brain injury (TBI) ICD code: \_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_

Other diagnosed residuals attributable to TBI, 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other diagnosis #4: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

If there are additional diagnoses that pertain to the residuals of a TBI, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s TBI and residuals attributable to TBI (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Yes  No

If yes, list only those medications used for the diagnosed condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION II. Assessment of cognitive impairment and other residuals of TBI**

NOTE: For each of the following 10 facets of TBI-related cognitive impairment and subjective symptoms (facets 1-10 below), select the ONE answer that best represents the Veteran’s current functional status.

Neuropsychological testing may need to be performed in order to be able to accurately complete this section. If neuropsychological testing has been performed and accurately reflects the Veteran’s current functional status, repeat testing is not required.

**1. Memory, attention, concentration, executive functions**

No complaints of impairment of memory, attention, concentration, or executive functions

A complaint of mild memory loss (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing

Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment

Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment

Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment

If the Veteran has complaints of impairment of memory, attention, concentration or executive functions, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Judgment**

Normal

Mildly impaired judgment. For complex or unfamiliar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision

Moderately impaired judgment. For complex or unfamiliar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, although has little difficulty with simple decisions

Moderately severely impaired judgment. For even routine and familiar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision

Severely impaired judgment. For even routine and familiar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision. For example, unable to determine appropriate clothing for current weather conditions or judge when to avoid dangerous situations or activities.

If the Veteran has impaired judgment, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Social interaction**

Social interaction is routinely appropriate

Social interaction is occasionally inappropriate

Social interaction is frequently inappropriate

Social interaction is inappropriate most or all of the time

If the Veteran’s social interaction is not routinely appropriate, describe (brief summary): \_\_\_\_\_\_\_\_

**4. Orientation**

Always oriented to person, time, place, and situation

Occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation

Occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation

Often disoriented to two or more of the four aspects (person, time, place, situation) of orientation

Consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation

If the Veteran is not always oriented to person, time, place, and situation, describe (brief summary): \_\_

**5. Motor activity (with intact motor and sensory system)**

Motor activity normal

Motor activity is normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function)

Motor activity is mildly decreased or with moderate slowing due to apraxia

Motor activity moderately decreased due to apraxia

Motor activity severely decreased due to apraxia

If the Veteran has any abnormal motor activity, describe (brief summary): \_\_\_\_\_\_

**6. Visual spatial orientation**

Normal

Mildly impaired. Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system)

Moderately impaired. Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS (global positioning system)

Moderately severely impaired. Gets lost even in familiar surroundings, unable to use assistive devices such as GPS (global positioning system)

Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment

If the Veteran has impaired visual spatial orientation, describe (brief summary): \_\_\_\_\_\_\_\_\_\_

**7. Subjective symptoms**

No subjective symptoms

Subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples are: mild or occasional headaches, mild anxiety

Three or more subjective symptoms that mildly interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light

Three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days

If the Veteran has subjective symptoms, describe (brief summary): \_\_\_\_\_\_

**8. Neurobehavioral effects**

NOTE: Examples of neurobehavioral effects of TBI include: irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, belligerence, apathy, lack of empathy, moodiness, lack of cooperation, inflexibility, and impaired awareness of disability. Any of these effects may range from slight to severe, although verbal and physical aggression are likely to have a more serious impact on workplace interaction and social interaction than some of the other effects.

No neurobehavioral effects

One or more neurobehavioral effects that do not interfere with workplace interaction or social interaction.

One or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them

One or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them

One or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction, or both on most days or that occasionally require supervision for safety of self or others

If the Veteran has any neurobehavioral effects, describe (brief summary): \_\_\_\_\_\_

**9. Communication**

Able to communicate by spoken and written language (expressive communication) and to comprehend spoken and written language.

Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas.

Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than occasionally but less than half of the time. Can generally communicate complex ideas

Inability to communicate either by spoken language, written language, or both, at least half of the time but not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs

Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both. Unable to communicate basic needs

If the Veteran is not able to communicate by or comprehend spoken or written language, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. Consciousness**

Normal

Persistent altered state of consciousness, such as vegetative state, minimally responsive state, coma.

If checked, describe altered state of consciousness (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION III**

**1. Residuals**

Does the Veteran have any subjective symptoms or any mental, physical or neurological conditions or residuals attributable to a TBI (such as migraine headaches or Meniere’s disease)?

Yes  No

If yes, check all that apply:

Motor dysfunction

If checked, ALSO complete specific Joint or Spine Questionnaire for the affected joint or spinal area.

Sensory dysfunction

If checked, ALSO complete appropriate Cranial or Peripheral Nerve Questionnaire.

Hearing loss and/or tinnitus

If checked, ALSO complete a Hearing Loss and Tinnitus Questionnaire.

Visual impairment

If checked, ALSO complete an Eye Questionnaire.

Alteration of sense of smell or taste

If checked, ALSO complete a Loss of Sense of Smell and Taste Questionnaire.

Seizures

If checked, ALSO complete a Seizure Disorder Questionnaire.

Gait, coordination, and balance

If checked, ALSO complete appropriate Questionnaire for underlying cause of gait and balance disturbance, such as Ear Questionnaire.

Speech (including aphasia and dysarthria)

If checked, ALSO complete appropriate Questionnaire.

Neurogenic bladder

If checked, ALSO complete appropriate Genitourinary Questionnaire.

Neurogenic bowel

If checked, ALSO complete appropriate Intestines Questionnaire.

Cranial nerve dysfunction

If checked, ALSO complete a Cranial Nerves Questionnaire.

Skin disorders

If checked, ALSO complete a Skin and/or Scars Questionnaire.

Endocrine dysfunction

If checked, ALSO complete an Endocrine Conditions Questionnaire.

Erectile dysfunction

If checked, ALSO complete Male Reproductive Conditions Questionnaire.

Headaches, including Migraine headaches

If checked, ALSO complete a Headache Questionnaire.

Meniere’s disease

If checked, ALSO complete an Ear Conditions Questionnaire.

Mental disorder (including emotional, behavioral, or cognitive)

If checked, ALSO complete Mental Disorders or PTSD Questionnaire.

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

If checked, ALSO complete appropriate Questionnaire.

**2. Other pertinent physical findings, scars, 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Diagnostic testing**

NOTE: If diagnostic test results are in the medical record and reflect the Veteran’s current TBI residuals, repeat testing is not required.

a. Has neuropsychological testing been performed?

Yes  No

If yes, provide date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Have diagnostic imaging studies or other diagnostic procedures been performed?

Yes  No

If yes, check all that apply:

Magnetic resonance imaging (MRI)

Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Computed tomography (CT)

Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

EEG

Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Has laboratory testing been performed?

Yes  No

If yes, specify tests: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Functional impact**

Do any of the Veteran’s residual conditions attributable to a traumatic brain injury impact his or her ability to work?

Yes  No

If yes, describe impact of each of the Veteran’s residual conditions attributable to a traumatic brain injury, providing one or more examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. 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.

## 6.20. DBQ Seizure Disorders (Epilepsy)

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 have or has he/she ever been diagnosed with a seizure disorder (epilepsy)?

Yes  No

If yes, check the appropriate diagnosis: (check all that apply)

Tonic-clonic seizures or grand mal (generalized convulsive seizures)

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

Absence seizures or petit mal or atonic seizures (generalized non-convulsive seizures)

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

Jacksonian (simple partial seizures) ICD code: \_\_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_

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

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

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

Psychomotor epilepsy (complex partial seizures, temporal lobe seizures)

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

Other, specify:

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

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

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

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

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

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

If there are additional diagnoses that pertain to seizure disorders (epilepsy), list using above format: \_\_\_

**2. Medical history**

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

b. Is continuous medication required for control of epilepsy or seizure activity?

Yes  No

If yes, list only those medications required for the Veteran’s epilepsy or seizure activity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Has the Veteran had any other treatment (such as surgery) for epilepsy or seizure activity?

Yes  No

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

d. Has the diagnosis of a seizure disorder been confirmed?

Yes  No

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

e. Has the Veteran had a witnessed seizure?

Yes  No

If yes, describe, including relationship of witnesses to Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Findings, signs and symptoms**

Does the Veteran have or has he or she had any findings, signs or symptoms attributable to seizure disorder

(epilepsy) activity?

Yes  No

If yes, check all that apply:

Generalized tonic-clonic convulsions

Episodes of unconsciousness

Brief interruption in consciousness or conscious control

Episodes of staring

Episodes of rhythmic blinking of the eyes

Episodes of nodding of the head

Episodes of sudden jerking movement of the arms, trunk or head (myoclonic type)

Episodes of sudden loss of postural control (akinetic type)

Episodes of complete or partial loss of use of one or more extremities

Episodes of random motor movements

Episodes of psychotic manifestations

Episodes of hallucinations

Episodes of perceptual illusions

Episodes of abnormalities of thinking

Episodes of abnormalities of memory

Episodes of abnormalities of mood

Episodes of autonomic disturbances

Episodes of speech disturbances

Episodes of impairment of vision

Episodes of disturbances of gait

Episodes of tremors

Episodes of visceral manifestations

Residuals of injury during seizure, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**4. Type and frequency of seizure activity**

Does the Veteran have or has he or she ever had any type of seizure activity, including major, minor, petit mal or psychomotor seizure activity?

Yes  No

If yes, complete the following:

a. Provide approximate date of first seizure activity: \_\_\_\_\_\_\_\_\_\_

Date of most recent seizure activity: \_\_\_\_\_\_\_\_\_\_\_

b. Has the Veteran ever had minor seizures (a minor seizure is characterized by a brief interruption in

consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the

head (“pure” petit mal) or sudden jerking movements of the arms, trunk or head (myoclonic type) or sudden

loss of postural control (akinetic type))?

Yes  No

If yes, complete the following:

Number of minor seizures over past 6 months:

0-1

2 or more

If 2 or more over the past 6 months, indicate the average frequency of minor seizures:

0-4 per week

5-8 per week

9-10 per week

More than 10 per week

c. Has the Veteran ever had major seizures (a major seizure is characterized by the generalized tonic-clonic

convulsion with unconsciousness)?

Yes  No

If yes, complete the following:

Number of major seizures:

None in past 2 years

At least 1 in past 2 years

At least 2 in past year

Average frequency of major seizures:

Less than 1 in past 6 months

At least 1 in past 6 months

At least 1 in 4 months over past year

At least 1 in 3 months over past year

At least 1 per month over past year

d. Has the Veteran ever had minor psychomotor seizures (minor psychomotor seizures are characterized by

brief transient episodes of random motor movements, hallucinations, perceptual illusions, abnormalities of

thinking, memory or mood, or autonomic disturbances)?

Yes  No

If yes, complete the following:

Number of minor psychomotor seizures over past 6 months:

0-1

2 or more

If 2 or more over the past 6 months, indicate the average frequency of minor psychomotor

seizures:

0-4 per week

5-8 per week

9-10 per week

More than 10 per week

e. Has the Veteran ever had major psychomotor seizures (major psychomotor seizures are characterized by

automatic states and/or generalized convulsions with unconsciousness)?

Yes  No

If yes, complete the following:

Number of major psychomotor seizures:

None in past 2 years

At least 1 in past 2 years

At least 2 in past year

Average frequency of major psychomotor seizures:

Less than 1 in past 6 months

At least 1 in past 6 months

At least 1 in 4 months over past year

At least 1 in 3 months over past year

At least 1 per month over past year

f. Has the Veteran ever had a nonpsychotic organic brain syndrome associated with epilepsy?

Yes  No

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

g. Has the Veteran ever had a psychotic disorder, psychoneurotic disorder, or personality disorder associated

with epilepsy?

Yes  No

If yes, the appropriate Mental Disorder Questionnaire must ALSO be completed.

**5. Other pertinent physical findings, scars, 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 related to any conditions listed in the Diagnosis section above?

Yes  No

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

**6. Diagnostic testing**

NOTE: If diagnostic test results are in the medical record and reflect the Veteran’s current seizure disorder

(epilepsy), repeat testing is not required.

a. Have any imaging studies or diagnostic procedures been performed?

Yes  No

If yes, check all that apply:

Magnetic resonance imaging (MRI) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Computed tomography (CT) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cerebrospinal fluid (CSF) examination Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_

Electroencephalography (EEG) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_

Neuropsychologic testing Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_

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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Functional impact**

Does the Veteran’s epilepsy or seizure (epilepsy) disorder impact his or her ability to work?

Yes  No

If yes, describe the impact of the Veteran’s seizure (epilepsy) disorder, providing one or more examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. 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.

## 6.21. DBQ Sinusitis/Rhinitis and other Conditions of the Nose, Throat, Larynx

## and Pharynx

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 sinus, nose, throat, larynx, or pharynx

condition?

Yes  No

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

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

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

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

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

Granulomatous rhinitis ICD code: \_\_\_\_\_\_Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

Pharyngeal injury, describe:

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

Deviated nasal septum (traumatic)

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

Anatomical loss of part of nose: Complete Scars DBQ in lieu of this Questionnaire.

Benign or malignant neoplasm of sinus, nose, throat, larynx or pharynx

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

Other, specify:

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 sinuses, nose, throat, larynx, or pharynx conditions, list

using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s sinus, nose, throat, larynx, or pharynx

condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Is continuous medication required for control of a sinus, nose, throat, larynx, or pharynx condition?

Yes  No

If yes, list only those medications required for the Veteran’s sinus, nose, throat, larynx, or pharynx condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Sinusitis**

Does the Veteran have chronic sinusitis?

Yes  No

If yes, complete the following:

a. Indicate the sinuses/type of sinusitis currently affected by the Veteran’s chronic sinusitis (check all that apply):

None  Maxillary  Frontal  Ethmoid  Sphenoid  Pansinusitis

b. Does the Veteran currently have any findings, signs or symptoms attributable to chronic sinusitis?

Yes  No

If yes, check all that apply:

Chronic sinusitis detected only by imaging studies (see Diagnostic testing section)

Episodes of sinusitis

Near constant sinusitis

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

Headaches

Pain and tenderness of affected sinus

Purulent discharge or crusting

For all checked conditions or for any other conditions, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Has the Veteran had NON-INCAPACITATING episodes of sinusitis characterized by headaches, pain and

purulent discharge or crusting in the past 12 months?

Yes  No

If yes, provide the total number of non-incapacitating episodes over the past 12 months:

1  2  3  4  5  6  7 or more

d. Has the Veteran had INCAPACITATING episodes of sinusitis requiring prolonged (4 to 6 weeks) of

antibiotics treatment in the past 12 months?

NOTE: For VA purposes, an incapacitating episode of sinusitis means one that requires bed rest and

treatment prescribed by a physician.

Yes  No

If yes, provide the total number of incapacitating episodes of sinusitis requiring prolonged (4 to 6 weeks) of

antibiotic treatment over past 12 months:

1  2  3 or more

e. Has the Veteran had sinus surgery?

Yes  No

If yes, specify type of surgery:

Radical Endoscopic  Other: \_\_\_\_\_\_\_\_

Date(s) of surgery (if repeated sinus surgery, provide all dates of surgery): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Veteran has had radical sinus surgery, did chronic osteomyelitis follow the surgery?

Yes  No

If yes, complete Osteomyelitis Questionnaire

**4. Rhinitis**

Does the Veteran have allergic, vasomotor, bacterial or granulomatous rhinitis?

Yes  No

If yes, complete the following:

a. Is there greater than 50% obstruction of the nasal passage on both sides due to rhinitis?

Yes  No

b. Is there complete obstruction on one side due to rhinitis?

Yes  No

c. Is there permanent hypertrophy of the nasal turbinates?

Yes  No

d. Are there nasal polyps?

Yes  No

e. Does the Veteran have any of the following granulomatous conditions?

Yes  No

If yes, check all that apply:

Granulomatous rhinitis  Rhinoscleroma  Wegener’s granulomatosis  Lethal midline granuloma

Other granulomatous infection, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Larynx and pharynx conditions**

Does the Veteran have chronic laryngitis, laryngectomy, aphonia, laryngeal stenosis, pharyngeal injury or any other pharyngeal conditions?

Yes  No

If yes, complete the following:

a. Does the Veteran have any of the following symptoms due to chronic laryngitis?

Yes  No

If yes, check all that apply:

Hoarseness

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

Inflammation of vocal cords or mucous membrane

Thickening or nodules of vocal cords

Submucous infiltration of vocal cords

Vocal cord polyps

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

b. Has the Veteran had a laryngectomy?

Yes  No

If yes, specify:

Total laryngectomy

Partial laryngectomy

If checked, does the Veteran have any residuals of the partial laryngectomy?

Yes  No

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

c. Does the Veteran have laryngeal stenosis, including residuals of laryngeal trauma (unilateral or bilateral)?

Yes  No

If yes, assess for upper airway obstruction with pulmonary function testing, to include Flow-Volume Loop, and provide results in Diagnostic testing section.

d. Does the Veteran have complete organic aphonia?

Yes  No

If yes, check all that apply:

Constant inability to speak above a whisper

Constant inability to communicate by speech

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

e. Does veteran have incomplete organic aphonia?

Yes  No

If yes, check all that apply:

Hoarseness

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

Inflammation of vocal cords or mucous membrane

Thickening or nodules of vocal cords

Submucous infiltration of vocal cords

Vocal cord polyps

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

f. Has the Veteran had a permanent tracheostomy?

Yes  No

g. Has the Veteran had an injury to the pharynx?

Yes  No

If yes, check all findings, signs and symptoms that apply:

Stricture or obstruction of the pharynx or nasopharynx

Absence of the soft palate secondary to trauma

Absence of the soft palate secondary to chemical burn

Absence of the soft palate secondary to granulomatous disease

Paralysis of the soft palate with swallowing difficulty (nasal regurgitation) and speech impairment

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

**6. Deviated nasal septum (traumatic)**

Does the Veteran have a deviated nasal septum due to trauma?

Yes  No

If yes, complete the following:

a. Is there at least 50% obstruction of the nasal passage on both sides due to traumatic septal deviation?

Yes  No

b. Is there complete obstruction on one side due to traumatic septal deviation?

Yes  No

**7. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Other pertinent physical findings, scars, 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 related to any conditions listed in the Diagnosis section above?

Yes  No

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

**9. Diagnostic testing**

NOTE: If diagnostic test results are in the medical record and reflect the Veteran’s current sinus, nose, throat, larynx or pharynx condition, repeat testing is not required.

a. Have imaging studies of the sinuses or other areas been performed?

Yes  No

If yes, check all that apply:

Magnetic resonance imaging (MRI) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Computed tomography (CT) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

X-rays: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Has endoscopy been performed?

Yes  No

If yes, complete the following:

If yes, check all that apply:

Nasal endoscopy             Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Laryngeal endoscopy      Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other endoscopy            Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Has the Veteran had a biopsy of the larynx or pharynx?

Yes  No

If yes, complete the following:

Site of biopsy: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_Results:

Benign  Pre-malignant  Malignant

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

d. Has the Veteran had pulmonary function testing to assess for upper airway obstruction due to laryngeal stenosis?

Yes  No

If yes, indicate results:

FEV-1 of 71 to 80% predicted

FEV-1 of 56 to 70% predicted

FEV-1 of 40 to 55% predicted

FEV-1 less than 40% predicted

Is the Flow-Volume Loop compatible with upper airway obstruction?

Yes  No

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 sinus, nose, throat, larynx or pharynx condition impact his or her ability to work?

Yes  No

If yes, describe impact of each of the Veteran’s sinus, nose, throat, larynx or pharynx 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.

## 6.22.DBQ Systemic Lupus Erythematosus (SLE) and other Autoimmune

## Diseases (other than HIV and Diabetes Mellitus Type I)

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 have or has he/she had a systemic or localized autoimmune disease, including systemic lupus erythematosus (SLE)?

Yes  No

If no, provide rationale (e.g., Veteran does not currently have any known autoimmune diseases, including SLE. Provide substantiating information including diagnostic test results, if available, to document the absence of these disorders): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, select the Veteran’s condition:

[Autoimmune polyglandular syndrome](http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=gnd&part=autoimmunepolyglandularsyndrome)

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

If this condition affects multiple endocrine glands, ALSO complete appropriate Questionnaire(s) for those conditions

Discoid lupus erythematosus ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_

[Familial Mediterranean fever](http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=gnd&part=familialmediterraneanfever) ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_

Goodpasture's syndrome ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_

If this condition affects the lungs or kidneys, ALSO complete appropriate Questionnaire(s) for those conditions.

[Guillain-Barre syndrome](http://www.labtestsonline.org/understanding/conditions/guillain.html) ICD code: \_\_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_

If this condition affects the nervous system, ALSO complete appropriate Questionnaire(s) for those conditions

[Immunodeficiency with hyper-IgM](http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=gnd&part=immunodeficiencywithhyperigm) ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_

[Polymyalgia rheumatica](javascript:%20optionsdisplay('../../glossary/polymyalgia.html')) ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_

If this condition affects large muscle groups, ALSO complete appropriate Questionnaire(s) for those conditions

[Rheumatoid arthritis (RA)](http://www.labtestsonline.org/understanding/conditions/rheumatoid.html) and [Juvenile RA (JRA)](http://www.labtestsonline.org/understanding/conditions/jra.html)

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

If this condition affects the joints, lungs or skin, ALSO complete appropriate Questionnaire(s) for those conditions

[Scleroderma](http://www.labtestsonline.org/understanding/conditions/scleroderma.html) ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_

If this condition affects the lungs, skin or intestines, ALSO complete appropriate

Questionnaire(s) for those conditions.

[Severe combined immunodeficiency](http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=gnd&part=severecombinedimmunodeficiency) ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_

[Sjögren's syndrome](http://www.labtestsonline.org/understanding/conditions/sjogren.html) ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_

If this condition affects the salivary glands, lacrimal glands, joints or kidneys, ALSO complete appropriate Questionnaire(s) for those conditions.

Subacute cutaneous lupus erythematosus

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

Systemic lupus erythematosus ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_

[Temporal arteritis](http://www.labtestsonline.org/glossary/tempart.html)/Giant cell arteritis ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_

Wegener's granulomatosis ICD code: \_\_\_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_

If this condition affects the blood vessels, sinuses, lungs or kidneys, ALSO complete appropriate Questionnaire(s).

Other, specify:

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

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

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

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

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

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

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

For all checked diagnoses, ALSO complete additional DBQs as appropriate to fully described effects of the condition.

If the Veteran has HIV, complete the HIV Questionnaire in lieu of this Questionnaire.

If the Veteran has Diabetes Mellitus Type I, complete the Diabetes Questionnaire in lieu of this Questionnaire.

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s autoimmune disease, including SLE (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Over the past 12 months, has the Veteran’s treatment plan included oral or topical medications for any autoimmune disease or autoimmune disorder-related skin condition, including systemic, cutaneous or discoid lupus?

Yes  No

If yes, check all that apply:

Oral corticosteroids

If checked, list medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 immunosuppressive medications

If checked, list medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Topical corticosteroids

If checked, list medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Total duration of topical corticosteroid use in past 12 months:

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

Other oral or topical medications used for an autoimmune condition

If checked, list medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Total duration of other oral medication use in past 12 months:

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

c. Indicate status of the Veteran’s autoimmune disease, including SLE:

Acute  Chronic  Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. Does the Veteran have exacerbations of an autoimmune disease, including SLE?

Yes  No

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

Indicate average frequency of exacerbations per year:

0  1  2  3  More than 3 exacerbations per year

Indicate average duration of symptoms during each exacerbation:

Lasting less than one week

Lasting a week or more

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

e. Does the Veteran’s autoimmune disease, including SLE, currently produce severe impairment of health?

Yes  No

If checked, describe the severe impairment of health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Cutaneous manifestations**

Does the Veteran have any cutaneous manifestations of an autoimmune disease, including systemic, cutaneous or discoid lupus erythematosus?

Yes  No

If yes, complete the following section:

a. Specify the cutaneous manifestations (check all that apply):

Discoid lupus erythematosus

Subacute cutaneous lupus erythematosus

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

b. Indicate areas affected by cutaneous manifestations (check all that apply):

Malar rash over bridge of nose and bilateral cheeks, sparing nasolabial folds

Cheeks

If checked, specify:  Right  Left  Both

Ears

If checked, specify:  Right  Left  Both

Nose

Chin

Lips and mouth, causing ulcers and scaling

Hands

Feet

Scalp, causing scarring alopecia

Other body areas, specify location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For all checked areas, describe cutaneous manifestations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Indicate approximate TOTAL body area affected by cutaneous manifestations of an autoimmune disease on current examination:

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

d. Indicate approximate total EXPOSED body area (face, neck and hands) affected by cutaneous manifestations of an autoimmune disease on current examination:

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

e. Do the cutaneous manifestations of the autoimmune disease cause scarring alopecia?

Yes  No

If yes, indicate percent of scalp affected:

< 20 %  20 to 40%  > 40%

f. Do the cutaneous manifestations of the autoimmune disease cause scarring (including surgical scars related to the condition, if any) that is unstable, painful, causes disfigurement of the head, face or neck, or has a total area of all related scars greater than 39 square cm (6 square inches)?

Yes  No

If yes, ALSO complete a Scars Questionnaire.

**4. Findings, signs and symptoms**

Does the Veteran have any findings, signs or symptoms (other than cutaneous manifestations) attributable to an autoimmune disease, including SLE?

Yes  No

If yes, complete the following section:

a. Has the Veteran had any symptoms (other than cutaneous manifestations) attributable to an autoimmune disease, including SLE, in the past 2 years?

Yes  No

b. Does the Veteran have arthritis attributable to an autoimmune disease, including SLE?

Yes  No

If yes, list affected joints and describe affect of autoimmune disease on each joint (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALSO complete appropriate Questionnaire for each affected joint.

c. Does the Veteran have recurrent ulcers on oral mucous membranes attributable to an autoimmune disease, including SLE?

Yes  No

If yes, do the recurrent ulcers results in impairment of mastication, a speech impairment or other signs or symptoms?

Yes  No

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

d. Does the Veteran have any hematologic or lymphatic manifestations of an autoimmune disease, including SLE?

Yes  No

If yes, check all that apply:

Generalized adenopathy

Splenomegaly

Anemia

Leukopenia (usually lymphopenia, with < 1500 cells/μL)

Thrombocytopenia (sometimes life-threatening autoimmune thrombocytopenia)

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

e. Does the Veteran have any pulmonary manifestations of an autoimmune disease, including SLE?

Yes  No

If yes, check all that apply (ALSO complete a Respiratory Questionnaire, including pulmonary function testing, if appropriate, on the Respiratory Questionnaire):

Pulmonary emboli

Pulmonary hypertension

Shrinking lung syndrome

Recurrent pleurisy, with or without pleural effusion

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

f. Does the Veteran have any cardiac manifestations of an autoimmune disease, including SLE?

Yes  No

If yes, check all that apply (ALSO complete a Heart Questionnaire):

Pericardial effusion

Myocarditis

Coronary artery vasculitis

Valvular involvement

Libman-Sacks endocarditis

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

g. Does the Veteran have any neurologic manifestations of an autoimmune disease, including SLE?

Yes  No

If yes, describe (ALSO complete the appropriate neurologic Questionnaire): \_\_\_\_\_\_\_\_\_\_\_\_\_

h. Does the Veteran have any renal manifestations of an autoimmune disease, including SLE?

Yes  No

If yes, check all that apply (ALSO complete the appropriate Kidney and/or Hypertension Questionnaire):

Glomerular nephritis

Membranoproliferative glomerulonephritis.

Proteinuria

Hypertension

Edema

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

i. Does the Veteran have any obstetric manifestations of an autoimmune disease, including SLE?

Yes  No

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

j. Does the Veteran have any gastrointestinal manifestations of an autoimmune disease, including SLE?

Yes  No

If yes, describe (ALSO complete the appropriate GI Questionnaire): \_\_\_\_\_\_\_

k. Does the Veteran have any vascular (arterial or venous) manifestations of an autoimmune disease, including SLE?

Yes  No

If yes, check all that apply (ALSO complete the Arteries & Veins Questionnaire):

Recurrent arterial thrombosis

Recurrent venous thrombosis

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

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

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

Yes  No

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

**6. Diagnostic testing**

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.

a. Have imaging studies been performed?

Yes  No

If yes, check all that apply:

Chest x-ray Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Magnetic resonance imaging (MRI) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Computed tomography (CT) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Has laboratory testing been performed?

Yes  No

If yes, check all that apply:

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

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

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

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

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

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

Erythrocyte sedimentation rate (ESR) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

C-reactive protein (CRP) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Antinuclear antibody (ANA) titer Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_

Anti-Ro Antibody Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anti-Smith antibodies Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anti-double strand (ds) DNA Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Antiphospolipid Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complement components (C3 and C4) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

BUN Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Creatinine Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estimated glomerular filtration rate (EGFR)

Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Has a urinalysis been performed?

Yes  No

Date of most recent urinalysis: \_\_\_\_\_\_\_\_\_\_\_

Results:

Microalbumin:  Not elevated  Elevated to: \_\_\_\_\_\_\_\_\_

Protein:  None  Trace  1+  2+  3+

Glucose:  None  Trace  1+  2+  3+

Hyaline casts:  None  1-5 hyaline casts per LPF  Other, describe: \_\_\_\_\_\_\_\_\_\_\_

Granular casts:  None  1-5 granular casts per LPF  Other, describe: \_\_\_\_\_\_\_\_\_\_\_

Blood:  None  Trace blood and no RBCs per HPF

Trace blood and 1-5 RBCs per HPF  1+ blood and 1-5 RBCs per HPF

1+ blood and 5-10 RBCs per HPF  2+ blood and 10-20 RBCs per HPF

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

d. 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Functional impact**

Does the Veteran’s autoimmune disease impact his or her ability to work?

Yes  No

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

**8. 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.

## 6.23. DBQ Thyroid and Parathyroid 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 have or has he/she ever had a thyroid or parathyroid condition?

Yes  No

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

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

Toxic adenoma of thyroid ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Non-toxic adenoma of thyroid (euthyroid)

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

Euthyroid multinodular goiter ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

C-cell hyperplasia ICD code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Benign neoplasm of the thyroid

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

Malignant neoplasm of the thyroid

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

Benign neoplasm parathyroid ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Malignant neoplasm parathyroid ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Other, specify:

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

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

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

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

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

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

If there are additional diagnoses that pertain to thyroid and/or parathyroid conditions, list using above format: \_\_\_\_

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s thyroid and/or parathyroid condition (brief

summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Is continuous medication required for control of a thyroid or parathyroid condition?

Yes  No

If yes, state the condition and list only those medications required for the Veteran’s thyroid and/or parathyroid

condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Has the Veteran had radioactive iodine treatment for a thyroid condition?

Yes  No

If yes, specify the condition and type of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

d. Has the Veteran had surgery for a thyroid or parathyroid condition?

Yes  No

If yes, specify the condition and type of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

e. Has the Veteran had any other type of treatment for a thyroid or parathyroid condition?

Yes  No

If yes, specify the condition and type of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

f. Does the Veteran have any residual endocrine dysfunction following treatment for thyroid or parathyroid condition?

Yes  No

If yes, check all that apply:

Hypothyroid endocrine dysfunction

Hypoparathyroid endocrine dysfunction

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

**3. Findings, signs and symptoms**

a. Does the Veteran currently have any findings, signs or symptoms attributable to a hyperthyroid condition?

Yes  No

If yes, check all that apply:

Tachycardia (more than 100 beats per minute)

If checked, indicate frequency of tachycardia:  Constant  Intermittent

Palpitations

Atrial fibrillation or other arrhythmia attributable to a thyroid condition

If checked, indicate frequency:  Constant  Intermittent (paroxysmal)

If intermittent, indicate number of episodes in the past 12 months:

0  1-3  More than 4

Indicate how these episodes were documented (check all that apply)

EKG  Holter  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Increased pulse pressure or blood pressure

Tremor

Emotional instability

Fatigability

Thyroid enlargement

Eye involvement (exophthalmos)

If checked, an Eye DBQ must ALSO be completed.

Muscular weakness

Increase sweating

Flushing

Heat intolerance

Frequent bowel movements

Irregular or absent menstrual periods in women

Weight loss attributable to a hyperthyroid condition

If checked, provide baseline weight: \_\_\_\_\_\_\_ and current weight: \_\_\_\_\_\_\_

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

For all checked conditions or for any other conditions, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Does the Veteran currently have any findings, signs or symptoms attributable to a hypothyroid condition?

Yes  No

If yes, check all that apply:

Fatigability

Constipation

Mental sluggishness

Mental disturbance (dementia, slowing of thought, depression)

Muscular weakness

Weight gain attributable to a hypothyroid condition

If checked, provide baseline weight: \_\_\_\_\_\_\_ and current weight: \_\_\_\_\_\_\_

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

Sleepiness

Cold intolerance

Bradycardia (less than 60 beats per minute)

For all checked conditions or for any other conditions, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Does the Veteran currently have any findings, signs or symptoms attributable to a hyperparathyroid condition?

Yes  No

If yes, check all that apply:

Weakness

Kidney stones

If checked, describe, providing dates and treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Generalized decalcification of bones

If checked, has the Veteran had a bone density test, such as a DEXA scan?

Yes  No

If yes, provide date of test: \_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_

Nausea

Vomiting

Constipation

Anorexia

Peptic ulcer

Weight loss attributable to hyperparathyroid condition

If checked, provide baseline weight: \_\_\_\_\_\_\_ and current weight: \_\_\_\_\_\_\_

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

For all checked conditions or for any other conditions, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. Does the Veteran currently have any findings, signs or symptoms attributable to hypoparathyroid condition?

Yes  No

If yes, check all that apply:

Paresthesias (of arms, legs or circumoral area)

Cataract

If checked, an Eye DBQ must also be completed.

Evidence of increased intracranial pressure (such as papilledema)

Marked neuromuscular excitability

Convulsions

Muscular spasms (tetany)

Laryngeal stridor

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

e. Does the Veteran currently have symptoms due to pressure on adjacent organs such as the trachea, larynx, or esophagus attributable to a thyroid condition?

Yes  No

If yes, indicate which adjacent organs are affected:

Larynx and/or trachea

If checked, report pulmonary function testing results in diagnostic testing section.

Esophagus

If checked, indicate severity of pressure-related symptoms/swallowing difficulty (check all that apply):

Mild  Moderate  Severe, permitting the passage of liquids only  Causing marked impairment of health

**4. Physical exam**

a. Eyes:  Normal, no exopthalmos

Abnormal

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

If abnormal, an Eye DBQ must also be completed.

b. Neck:  Normal, no palpable thyroid enlargement or nodules

Abnormal, diffusely enlarged thyroid gland

Abnormal, enlarged thyroid nodule

If checked, describe location, size and consistency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abnormal, with disfigurement of the head or neck due to enlargement of the thyroid gland

If checked, describe by following Section 6 below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

c. Pulse:  Regular  Irregular

Heart rate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. Blood pressure x3 \_\_\_\_\_\_\_\_\_\_

**5. Reflex exam**

Rate deep tendon reflexes (DTRs) according to the following scale:

0 Absent

1+ Hypoactive

2+ Normal

3+ Hyperactive without clonus

4+ Hyperactive with clonus

All normal

Biceps: Right:  0  1+  2+  3+  4+

Left:  0  1+  2+  3+  4+

Triceps: Right:  0  1+  2+  3+  4+

Left:  0  1+  2+  3+  4+

Brachioradialis: Right:  0  1+  2+  3+  4+

Left:  0  1+  2+  3+  4+

Knee: Right:  0  1+  2+  3+  4+

Left:  0  1+  2+  3+  4+

Ankle: Right:  0  1+  2+  3+  4+

Left:  0  1+  2+  3+  4+

**6. Scars or other disfigurement of the neck**

Does the Veteran have any scars of the neck related to treatment for any thyroid or parathyroid condition?

Yes  No

If yes, complete the following:

a. Total number of unstable or painful scars:  0  1  2  3  4  5 or more

b. Is any scar 13 cm in length or longer?

Yes  No

c. Is any scar 0.6 cm in width or wider?

Yes  No

d. Is any scar elevated or depressed?

Yes  No

e. Is any scar adherent to underlying tissue?

Yes  No

Does the Veteran have any areas of skin of the neck that are hypo- or hyperpigmented, that have abnormal texture,

that have missing underlying soft tissue, or that are indurated and inflexible due to thyroid or parathyroid disease or

their treatment?

Yes  No

a. If yes, provide approximate total area of skin with hypo- or hyperpigmented area(s): \_\_\_\_\_\_\_\_\_\_\_ cm2

b. If yes, provide approximate total area of skin with area(s) of abnormal texture: \_\_\_\_\_\_\_\_\_\_\_\_\_cm2

c. If yes, provide approximate total area of skin with area(s) of missing underlying soft tissue: \_\_\_\_\_\_\_\_ cm2

d. If yes, provide approximate total area of skin with area(s) that are indurated and inflexible: \_\_\_\_\_\_\_ cm2

**7. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Other pertinent physical findings, scars, 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 (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Diagnostic testing**

NOTE: If diagnostic test results are in the medical record and reflect the Veteran’s current thyroid or parathyroid

condition, repeat testing is not required.

a. Have imaging studies been performed?

Yes  No

If yes, check all that apply:

Magnetic resonance imaging (MRI) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Computed tomography (CT) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid scan Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid ultrasound Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Has laboratory testing been performed?

Yes  No

If yes, check all that apply and provide date of most recent test and results:

TSH Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

T4 Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

T3 Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid antibodies Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parathyroid hormone (PTH) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Calcium Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ionized calcium Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Have pulmonary function tests (PFTs) been performed?

NOTE: For VA purposes, PFTs should be performed if there is pressure on the larynx or trachea attributable to a

thyroid condition.

Yes  No

If yes, provide most recent results, if available:

FEV-1: \_\_\_\_\_\_\_\_\_\_\_% predicted Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

FEV-1/FVC: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

FVC: \_\_\_\_\_\_\_\_\_\_\_\_% predicted Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Is flow-volume loop compatible with upper airway obstruction?

Yes  No

d. Has a biopsy been performed?

Yes  No Site of biopsy: \_\_\_\_\_\_\_\_\_\_\_\_ Date of test: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 thyroid or parathyroid condition impact his or her ability to work?

Yes  No

If yes, describe impact of the Veteran’s thyroid and/or parathyroid condition, 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.

## 6.24. DBQ Urinary Tract (including Bladder & Urethra) Conditions (excluding

## Male Reproductive Organs)

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 condition of the bladder or urethra of the

urinary tract?

Yes  No

If yes, provide only diagnoses that pertain to urinary tract conditions of the bladder or urethra.

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 the bladder or urethra, list using above format: \_\_\_\_\_\_\_\_

**2. Medical history**

Describe the history (including onset and course) the Veteran’s urinary tract condition (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Voiding dysfunction**

Does the Veteran have a voiding dysfunction?

Yes  No

If yes, complete the following section:

a. Etiology of voiding dysfunction (i.e., relationship of voiding dysfunction to any condition in the Diagnosis section): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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. Urolithiasis**

Does the Veteran have a history of urethral or bladder calculi (cysto- or urethrolithiasis)?

Yes  No

If yes, complete the following section:

a. Indicate location of calculi (check all that apply):

Urethra  Bladder

b. Has the Veteran had treatment for recurrent stone formation in the urethra 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 signs or symptoms due to cysto- or urethrolithiasis?

Yes  No

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

Bladder pain

Dysuria

Hematuria

Voiding dysfunction

Requirement for catheter drainage

Sudden painful interruption of urinary stream

For all checked conditions or for any other conditions, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Bladder or urethral infection**

Does the Veteran have a history of recurrent symptomatic bladder or urethral infections?

Yes  No

If yes, complete the following section:

a. Provide etiology (i.e., relationship of recurrent symptomatic bladder or urethral infections to any condition

in the Diagnosis section): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. If the Veteran has had recurrent symptomatic urethral or bladder 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. Other bladder/urethral conditions**

Does the Veteran now have or has the Veteran had a bladder or urethral fistula, stricture, neurogenic bladder or bladder injury?

Yes  No

If yes, complete the following section:

a. Does the Veteran have any findings, signs or symptoms attributable to a bladder or urethral fistula?

Yes  No

If yes, check all that apply:

Voiding dysfunction (urine leakage, obstructed voiding)

Requirement for catheter drainage

Infection (cystitis or urethritis)

Impaired kidney function

If the Veteran has impaired kidney function, also complete Nephrology (Kidney Conditions) Questionnaire.

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

b. Has the Veteran had surgery for a bladder or urethral fistula?

Yes  No

If yes, indicate surgical treatment:

None

Resection or closure of fistula Date and facility of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urinary diversion Date and facility of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partial bladder resection Date and facility of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other, describe: \_\_\_\_\_\_ Date and facility of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Does the Veteran have a neurogenic bladder?

Yes  No

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

d. Has the Veteran had a bladder injury?

Yes  No

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

**7. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Other pertinent physical findings, scars, 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Diagnostic testing**

NOTE: If diagnostic test results are in the medical record and reflect the Veteran’s current urinary tract

condition, repeat testing is not required.

Has the Veteran had diagnostic testing and if so, are there significant 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 condition(s) of the bladder or urethra impact his or her ability to work?

Yes  No

If yes, describe impact of each of the Veteran’s bladder or urethra 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.

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\*175.

## 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\_P175\_RN.PDF** | Binary | Release Notes |
| **DVBA\_27\_P175\_DBQ\_MALEREPRODUCTIVE\_WF.docx** | Binary | Workflow Document |

## 7.3 Related Documents

The VistA Documentation Library (VDL) web site will also contain the DVBA\*2.7\*175 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 are communicated by the Disability Examination Management Office

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