



**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*174**

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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*174. (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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1. Purpose

The purpose of this document is to provide an overview of the enhancements and modifications functionality specifically designed for Patch DVBA*2.7*174.

Patch DVBA *2.7*174 (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).

2. Overview

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

- **DBQ BREAST CONDITIONS AND DISORDERS**
- **DBQ CENTRAL NERVOUS SYSTEM AND NEUROMUSCULAR DISEASES (EXCEPT TBI, ALS, PD, MS, HEADACHES, TMJ, EPILEPSY, NARCOLEPSY, PN, SA, CND, FIBROMYALGIA, AND CFS)**
- **DBQ EAR CONDITIONS**
- **DBQ ESOPHAGEAL CONDITIONS (INCLUDING GASTROESOPHAGEAL REFLUX DISEASE (GERD), HIATAL HERNIA AND OTHER ESOPHAGEAL DISORDERS)**
- **DBQ GALLBLADDER AND PANCREAS CONDITIONS**
- **DBQ GYNECOLOGICAL CONDITIONS**
- **DBQ HEADACHES (INCLUDING MIGRAINE HEADACHES)**
- **DBQ HEPATITIS, CIRRHOSIS AND OTHER LIVER CONDITIONS**
- **DBQ INFECTIOUS INTESTINAL DISORDERS, INCLUDING BACTERIAL AND PARASITIC INFECTIONS**
- **DBQ INTESTINAL CONDITIONS (OTHER THAN SURGICAL OR INFECTIOUS), INCLUDING IRRITABLE BOWEL SYNDROME, CROHN'S DISEASE, ULCERATIVE COLITIS AND DIVERTICULITIS**
- **DBQ INTESTINAL SURGERY (BOWEL RESECTION, COLOSTOMY AND ILEOSTOMY)**
- **DBQ MULTIPLE SCLEROSIS (MS)**
- **DBQ NON-DEGENERATIVE ARTHRITIS (INCLUDING INFLAMMATORY AUTOIMMUNE, CRYSTALLINE AND INFECTIOUS ARTHRITIS) AND DYSBARIC OSTEONECROSIS**
- **DBQ OSTEOMYELITIS**
- **DBQ PERITONEAL ADHESIONS**
- **DBQ RECTUM AND ANUS CONDITIONS (INCLUDING HEMORRHOIDS)**
- **DBQ SLEEP APNEA**
- **DBQ STOMACH AND DUODENAL CONDITIONS**

In addition this patch addresses the following DBQs defect fixes:

- **DBQ HEART CONDITIONS (INCLUDING ISCHEMIC AND NON ISCHEMIC HEART DISEASE, ARRHYTHMIAS, VALVULAR DISEAS AND CARDIAC SURGERY)**
- **DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCUDING LEUKEMIA**
- **DBQ MEDICAL OPINION 1**
- **DBQ MEDICAL OPINION 2**
- **DBQ MEDICAL OPINION 3**
- **DBQ MEDICAL OPINION 4**
- **DBQ MEDICAL OPINION 5**

3. Associated Remedy Tickets & New Service Requests

There are no Remedy tickets or New Service Requests associated with patch DVBA*2.7*174.

4. Defects Fixes

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

- **DBQ HEART CONDITIONS (INCLUDING ISCHEMIC AND NON ISCHEMIC HEART DISEASE, ARRHYTHMIAS, VALVULAR DISEASE AND CARDIAC SURGERY)**
- **DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCUDING LEUKEMIA**
- **DBQ MEDICAL OPINION 1**
- **DBQ MEDICAL OPINION 2**
- **DBQ MEDICAL OPINION 3**
- **DBQ MEDICAL OPINION 4**
- **DBQ MEDICAL OPINION 5**

5. Enhancements

This section provides an overview of the modifications and primary functionality that will be delivered in Patch DVBA*2.7*174.

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 BREAST CONDITIONS AND DISORDERS**

- **DBQ CENTRAL NERVOUS SYSTEM AND NEUROMUSCULAR DISEASES (EXCEPT TBI, ALS, PD, MS, HEADACHES, TMJ, EPILEPSY, NARCOLEPSY, PN, SA, CND, FIBROMYALGIA, AND CFS)**
- **DBQ EAR CONDITIONS**
- **DBQ ESOPHAGEAL CONDITIONS (INCLUDING GASTROESOPHAGEAL REFLUX DISEASE (GERD), HIATAL HERNIA AND OTHER ESOPHAGEAL DISORDERS)**
- **DBQ GALLBLADDER AND PANCREAS CONDITIONS**
- **DBQ GYNECOLOGICAL CONDITIONS**
- **DBQ HEADACHES (INCLUDING MIGRAINE HEADACHES)**
- **DBQ HEPATITIS, CIRRHOSIS AND OTHER LIVER CONDITIONS**
- **DBQ INFECTIOUS INTESTINAL DISORDERS, INCLUDING BACTERIAL AND PARASITIC INFECTIONS**
- **DBQ INTESTINAL CONDITIONS (OTHER THAN SURGICAL OR INFECTIOUS), INCLUDING IRRITABLE BOWEL SYNDROME, CROHN'S DISEASE, ULCERATIVE COLITIS AND DIVERTICULITIS**
- **DBQ INTESTINAL SURGERY (BOWEL RESECTION, COLOSTOMY AND ILEOSTOMY)**
- **DBQ MULTIPLE SCLEROSIS (MS)**
- **DBQ NON-DEGENERATIVE ARTHRITIS (INCLUDING INFLAMMATORY AUTOIMMUNE, CRYSTALLINE AND INFECTIOUS ARTHRITIS) AND DYSBARIC OSTEONECROSIS**
- **DBQ OSTEOMYELITIS**
- **DBQ PERITONEAL ADHESIONS**
- **DBQ RECTUM AND ANUS CONDITIONS (INCLUDING HEMORRHOIDS)**
- **DBQ SLEEP APNEA**
- **DBQ STOMACH AND DUODENAL CONDITIONS**

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 BREAST CONDITIONS AND DISORDERS**
- **DBQ CENTRAL NERVOUS SYSTEM DISEASES**
- **DBQ EAR CONDITIONS**
- **DBQ ESOPHAGEAL CONDITIONS**
- **DBQ GALLBLADDER AND PANCREAS CONDITIONS**
- **DBQ GYNECOLOGICAL CONDITIONS**
- **DBQ HEADACHES (INCLUDING MIGRAINE HEADACHES)**
- **DBQ INFECTIOUS INTESTINAL DISORDERS**
- **DBQ INTESTINAL CONDITIONS (OTHER THAN SURGICAL OR INFECTIOUS),**
- **DBQ INTESTINAL (OTHER THAN SURGICAL OR INFECTIOUS)**
- **DBQ HEPATITIS, CIRRHOSIS AND OTHER LIVER CONDITIONS**
- **DBQ MULTIPLE SCLEROSIS (MS)**
- **DBQ NON-DEGENERATIVE ARTHRITIS**
- **DBQ OSTEOMYELITIS**
- **DBQ PERITONEAL ADHESIONS**
- **DBQ RECTUM AND ANUS CONDITIONS (INCLUDING HEMORRHOIDS)**
- **DBQ SLEEP APNEA**

- **DBQ STOMACH AND DUODENAL CONDITIONS**

5.3. CAPRI Template Defects

5.3.1. DBQ Heart Condition

Issue

In the “**Diagnostic Testing,**” section, when “**Chest X-ray Abnormal**” option is selected and data is entered in the describe text box, the data does not appear on the report.

Resolution

DBQ Heart Conditions (Including Ischemic and Non Ischemic Heart Disease, Arrhythmias, Valvular Disease and Cardiac Surgery) has been modified to display the description on the report.

5.3.2. DBQ Medical Opinions 1, 2, 3, 4, and 5

Issue

Copying and pasting “Medical Opinion” into section two does not paste the complete text.

Resolution

Section 2 of DBQ(s) MEDICAL OPINION 1, 2, 3, 4 and 5 has been changed from an edit box to memo box to allow acceptance of more text.

5.3.3. DBQ Hematologic and Lymphatic Conditions, Including Leukemia

Issue

In the “**Diagnostic Testing,**” section when “**Plasmacytoma**” option is selected the ICD code is entered, the user receives an error message that the ICD code needs to be entered.

Resolution

DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA has been updated with a fix.

6. Disability Benefits Questionnaires (DBQs)

The following section illustrates the content of the new questionnaires included in Patch DVBA*2.7*174.

6.1. DBQ Breast Conditions and Disorders

Name of patient/Veteran: _____ SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever had a disorder of the breast(s)?

Yes No

If yes, provide only diagnoses that pertain to the breast(s):

Diagnosis #1: _____

ICD code: _____

Date of diagnosis #1: _____

Diagnosis #2: _____

ICD code: _____

Date of diagnosis #2: _____

Diagnosis #3: _____

ICD code: _____

Date of diagnosis #3: _____

If there are additional diagnoses that pertain to breast(s), list using above format: _____

2. Medical history

a. Describe the history (including onset and course) of the Veteran's breast condition: _____

b. Does the Veteran have, or have a history of, a neoplasm of the breast?

Yes No

If yes, is or was there a malignant neoplasm?

Yes No

If yes, Right Left Both

If yes, were there or are there currently any metastases?

Yes No

If yes, describe locations: _____

If yes, is or was there a benign neoplasm?

Yes No

If yes, Right Left Both

3. Treatment/surgery

a. Has the Veteran completed any type of treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm and/or metastases?

Yes No; watchful waiting

If yes, indicate treatment type(s) (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: _____

Side: Right Left Both

Antineoplastic chemotherapy _____ Date of most recent treatment: _____

Date of completion of treatment or anticipated date of completion: _____

Other therapeutic procedure and/or treatment

Date of most recent procedure: _____

Date of completion of treatment or anticipated date of completion: _____

Describe the other treatment and/or procedure: _____

b. Has the Veteran undergone breast surgery?

Yes No

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

Wide local excision (For VA purposes, wide local excision means removal of a portion of the breast tissue and includes partial mastectomy, lumpectomy, tylectomy, segmentectomy, and quadrantectomy)

Right Left Both

Simple (or total) mastectomy (For VA purposes, a simple (or total) mastectomy means removal of all of the breast tissue, nipple, and a small portion of the overlying skin, but lymph nodes and muscles are left intact)

Right Left Both

Modified radical mastectomy (For VA purposes, a modified radical mastectomy means removal of the entire breast and axillary lymph nodes, in continuity with the breast, with pectoral muscles left intact)

Right Left Both

Radical mastectomy (For VA purposes, radical mastectomy means removal of the entire breast, underlying pectoral muscles and regional lymph nodes up to the coracoclavicular ligament)

Right Left Both

Axillary or sentinel lymph node excision

Right Left Both

Significant alteration of size or form

Right Left Both

Biopsy

Right Left Both

Other: _____

Right Left Both

c. Are there any residual conditions caused by the benign or malignant neoplasm or its treatment (e.g., arm swelling, nerve damage to arm)?

Yes No

If yes, briefly describe the conditions and complete appropriate Questionnaire: _____

4. Objective findings and residuals

Did the surgery or radiation treatment result in the loss of 25 percent or more tissue from a single breast or both breasts in combination?

Yes No

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

Yes No

If yes, describe (brief summary): _____

6. Diagnostic testing

NOTE: If imaging and/or diagnostic test results are in the medical record and reflect the Veteran's current condition, repeat testing is not required.

Has the Veteran had imaging and/or 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): _____

7. Functional impact

Does the Veteran's breast condition(s) impact his or her ability to work?

Yes No

If yes, describe impact of each of the Veteran's breast conditions, 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.

6.2. DBQ Central Nervous System and Neuromuscular Diseases (except Traumatic Brain Injury, Amyotrophic Lateral Sclerosis, Parkinson's disease, Multiple Sclerosis, Headaches, TMJ Conditions, Epilepsy, Narcolepsy, Peripheral Neuropathy, Sleep Apnea, Cranial Nerve Disorders, Fibromyalgia, and 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 he/she ever been diagnosed with a central nervous system (CNS) condition?

Yes No

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

CNS infections: ICD Code: _____ Date of Diagnosis: _____

Meningitis

Specify organism: _____

Brain abscess

Specify organism: _____

HIV

Neurosyphilis

Lyme disease

Encephalitis, epidemic, chronic, including poliomyelitis, anterior (anterior horn cells)

Other: specify: _____

Vascular diseases ICD code: _____ Date of diagnosis: _____

Thrombosis, TIA or cerebral infarction

Hemorrhage, specify type: _____

Cerebral arteriosclerosis

Other: specify: _____

Hydrocephalus ICD code: _____ Date of diagnosis: _____

Obstructive

Communicating

Normal pressure (NPH)

Brain tumor ICD code: _____ Date of diagnosis: _____

Spinal Cord conditions ICD code: _____ Date of diagnosis: _____

Syringomyelia

Myelitis

Hematomyelia

Spinal Cord injuries

Radiation injury

Electric or lightning injury

Decompression sickness (DCS)

Other: specify: _____

Spinal cord tumor

Other: specify: _____

Brain Stem Conditions ICD code: _____ Date of diagnosis: _____

Bulbar palsy

Pseudobulbar palsy

Other: specify: _____

- Movement disorders
 - Athetosis, acquired
 - Myoclonus I
 - Paramyoclonus multiplex (convulsive state, myoclonic type)
 - Tic, convulsive (Gilles de la Tourette syndrome)
 - Dystonia, specify type: _____
 - Essential tremor
 - Tardive dyskinesia or other neuroleptic induced syndromes
 - Other: specify: _____
- Neuromuscular disorders
 - Myasthenia gravis
 - Myasthenic syndrome
 - Botulism
 - Hereditary muscular disorders specify: _____
 - Familial periodic paralysis
 - Myoglobulinuria
 - Dermatomyositis or polyomyositis, specify: _____
 - Other: specify: _____
- Intoxications
 - Heavy metal intoxication
 - Specify: _____
 - Solvents
 - Specify: _____
 - Insecticides, pesticides, others
 - Specify: _____
 - Nerve gas agents
 - Herbicides/defoliants
 - Specify: _____
 - Other: specify: _____

Other central nervous 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 central nervous conditions, list using above format: _____

2. Medical history

a. Describe the history (including onset and course) of the Veteran's central nervous conditions (brief summary):

b. Does the Veteran's central nervous system condition require continuous medication for control?

Yes No

If yes, list medications used for central nervous system conditions: _____

c. Does the Veteran have an infectious condition?

Yes No

If yes, is it active?

Yes No

If no, describe residuals if any: _____

- d. Dominant hand
 Right Left Ambidextrous

3. Conditions, signs and symptoms

- a. Does the Veteran have any muscle weakness in the upper and/or lower extremities?
 Yes No

If yes, report under strength testing in neurologic exam section.

- b. Does the Veteran have any pharynx and/or larynx and/or swallowing conditions?
 Yes No

If yes, check all that apply:

- Constant inability to communicate by speech
- Speech not intelligible or individual is aphonic
- Paralysis of soft palate with swallowing difficulty (nasal regurgitation) and speech impairment
- Hoarseness
- Mild swallowing difficulties
- Moderate swallowing difficulties
- Severe swallowing difficulties, permitting passage of liquids only
- Requires feeding tube due to swallowing difficulties
- Other, describe: _____

- c. Does the Veteran have any respiratory conditions (such as rigidity of the diaphragm, chest wall or laryngeal muscles)?

- Yes No

If yes, provide PFT results under "Diagnostic testing" section.

- d. Does the Veteran have sleep disturbances?

- Yes No

If yes, check all that apply:

- Insomnia
- Hypersomnolence and/or daytime "sleep attacks"
- Persistent daytime hypersomnolence
- Sleep apnea requiring the use of breathing assistance device such as continuous positive airway pressure (CPAP) machine
- Sleep apnea causing chronic respiratory failure with carbon dioxide retention or cor pulmonale
- Sleep apnea requiring tracheostomy

- e. Does the Veteran have any bowel functional impairment?

- Yes No

If yes, check all that apply:

- Slight impairment of sphincter control, without leakage
- Constant slight impairment of sphincter control, or occasional moderate leakage
- Occasional involuntary bowel movements, necessitating wearing of a pad
- Extensive leakage and fairly frequent involuntary bowel movements
- Total loss of bowel sphincter control
- Chronic constipation
- Other bowel impairment (describe): _____

- f. Does the Veteran have voiding dysfunction causing urine leakage?

- Yes No

If yes, please check one:

- Does not require/does not use absorbent material
- Requires absorbent material that is changed less than 2 times per day
- Requires absorbent material that is changed 2 to 4 times per day
- Requires absorbent material that is changed more than 4 times per day

g. Does the Veteran have voiding dysfunction causing signs and/or symptoms of 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

h. Does the Veteran have voiding dysfunction causing findings, signs and/or symptoms of obstructed voiding?
 Yes No

If yes, check all signs and symptoms 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 or continuous catheterization

i. Does the Veteran have voiding dysfunction requiring the use of an appliance?
 Yes No

If yes, describe: _____

j. Does the Veteran have a history of recurrent symptomatic urinary tract infections?
 Yes No

If yes, check all treatments that apply:

- No treatment
- Long-term drug therapy
If checked, list medications used for urinary tract infection and indicate dates for courses of treatment over the past 12 months: _____
- Hospitalization
If checked, indicate frequency of hospitalization:
 1 or 2 per year
 More than 2 per year

Drainage
If checked, indicate dates when drainage performed over past 12 months: _____

Other management/treatment not listed above
Description of management/treatment including dates of treatment: _____

k. Does the Veteran (if male) have erectile dysfunction?

Yes No

If yes, is the erectile dysfunction as likely as not (at least a 50% probability) attributable to a CNS disease (including treatment or residuals of treatment)?

Yes No

If no, provide the etiology of the erectile dysfunction: _____

If yes, is the Veteran able to achieve an erection (without medication) sufficient for penetration and ejaculation?

Yes No

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

Yes No

4. Neurologic exam

a. Speech

Normal Abnormal

If speech is abnormal, describe: _____

b. Gait

Normal Abnormal, describe: _____

If gait is abnormal, and the Veteran has more than one medical condition contributing to the abnormal gait, identify the conditions and describe each condition's contribution to the abnormal gait: _____

c. Strength

Rate strength according to the following scale:

- 0/5 No muscle movement
- 1/5 Visible muscle movement, but no joint movement
- 2/5 No movement against gravity
- 3/5 No movement against resistance
- 4/5 Less than normal strength
- 5/5 Normal strength

All normal

Elbow flexion:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Elbow extension:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Wrist flexion:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Wrist extension:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Grip:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Pinch (thumb to index finger):	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5

Knee extension: Right: 5/5 4/5 3/5 2/5 1/5 0/5
 Left: 5/5 4/5 3/5 2/5 1/5 0/5

Ankle plantar flexion: Right: 5/5 4/5 3/5 2/5 1/5 0/5
 Left: 5/5 4/5 3/5 2/5 1/5 0/5

Ankle dorsiflexion: Right: 5/5 4/5 3/5 2/5 1/5 0/5
 Left: 5/5 4/5 3/5 2/5 1/5 0/5

d. Deep tendon reflexes (DTRs)

Rate reflexes according to the following scale:

- 0 Absent
- 1+ Decreased
- 2+ Normal
- 3+ Increased without clonus
- 4+ Increased 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+

e. Does the Veteran have muscle atrophy attributable to a CNS condition?

Yes No

If muscle atrophy is present, indicate location: _____

When possible, provide difference measured in cm between normal and atrophied side, measured at maximum muscle bulk: _____ cm.

f. Summary of muscle weakness in the upper and/or lower extremities attributable to a CNS condition (check all that apply):

Right upper extremity muscle weakness:

None Mild Moderate Severe With atrophy Complete (no remaining function)

Left upper extremity muscle weakness:

None Mild Moderate Severe With atrophy Complete (no remaining function)

Right lower extremity muscle weakness:

None Mild Moderate Severe With atrophy Complete (no remaining function)

Left lower extremity muscle weakness:

None Mild Moderate Severe With atrophy Complete (no remaining function)

NOTE: If the Veteran has more than one medical condition contributing to the muscle weakness, identify the condition(s) and describe each condition's contribution to the muscle weakness: _____

5. Tumors and neoplasms

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

Yes No

If yes, complete the following:

b. Is the neoplasm:

Benign Malignant

c. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?

Yes No; watchful waiting

If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

Treatment completed; currently in watchful waiting status

Surgery

If checked, describe: _____

Date(s) of surgery: _____

Radiation therapy

Date of most recent treatment: _____

Date of completion of treatment or anticipated date of completion: _____

Antineoplastic chemotherapy

Date of most recent treatment: _____

Date of completion of treatment or anticipated date of completion: _____

Other therapeutic procedure

If checked, describe procedure: _____

Date of most recent procedure: _____

Other therapeutic treatment

If checked, describe treatment: _____

Date of completion of treatment or anticipated date of completion: _____

d. Does the Veteran currently have any residual conditions or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?

Yes No

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

e. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the Diagnosis section, describe using the above format: _____

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the Diagnosis section above?

Yes No

If yes, describe (brief summary): _____

7. Mental health manifestations due to CNS condition or its treatment

a. Does the Veteran have depression, cognitive impairment or dementia, or any other mental health conditions attributable to a CNS disease and/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 Health Questionnaire (schedule with appropriate provider).

If yes, briefly describe the Veteran's mental health condition:

8. Differentiation of Symptoms or Neurologic Effects

Are you able to differentiate what portion of the symptomatology or neurologic effects above are caused by each diagnosis?

Yes No

If yes, list which symptoms or neurologic effects are attributable to each diagnosis, where possible:

9. 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: _____

10. Remaining effective function of the extremities

Due to a CNS condition, 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): _____

11. Diagnostic testing

NOTE: If the results of MRI, other imaging studies or other diagnostic tests are in the medical record and reflect the Veteran's current condition, repeat testing is not required. If pulmonary function testing (PFT) is indicated due to respiratory disability, and results are in the medical record and reflect the Veteran's current respiratory function, repeat testing is not required. DLCO and bronchodilator testing is not indicated for a restrictive respiratory disability such as that caused by muscle weakness due to CNS conditions.

a. Have imaging studies been performed?

Yes No

If yes, provide most recent results, if available: _____

b. Have PFTs been performed?

Yes No

If yes, provide most recent results, if available:

FEV-1: _____ % predicted Date of test: _____

FEV-1/FVC: _____ % predicted Date of test: _____

FVC: _____ % predicted Date of test: _____

c. If PFTs have been performed, is the flow-volume loop compatible with upper airway obstruction?
 Yes No

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): _____

12. Functional impact

Do the Veteran's central nervous system disorders impact his or her ability to work?

Yes No

If yes, describe impact of each of the Veteran's central nervous system disorder condition(s), providing one or more examples: _____

13. Remarks, if any: _____

Physician signature: _____ Date: _____

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.3. DBQ Ear Conditions (Including Vestibular and Infectious 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 ear or peripheral vestibular condition?

Yes No

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

- Meniere's syndrome or endolymphatic hydrops ICD code: _____ Date of diagnosis: _____
- Peripheral vestibular disorder ICD code: _____ Date of diagnosis: _____
- Benign Paroxysmal Positional Vertigo (BPPV) ICD code: _____ Date of diagnosis: _____
- Chronic otitis externa ICD code: _____ Date of diagnosis: _____
- Chronic suppurative otitis media ICD code: _____ Date of diagnosis: _____
- Chronic nonsuppurative otitis media (serous otitis media)
- Mastoiditis ICD code: _____ Date of diagnosis: _____
- Cholesteatoma ICD code: _____ Date of diagnosis: _____

If checked, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed.

- Otosclerosis
If checked, a Hearing Loss and Tinnitus Questionnaire must be completed in lieu of this Questionnaire.
- Benign neoplasm of the ear (other than skin only)
- Malignant neoplasm of the ear (other than skin only)
- 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 ear or peripheral vestibular conditions, list using above format: _____

NOTE: If the Veteran has hearing loss or tinnitus attributable to any ear condition listed above, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed.

2. Medical history

a. Describe the history (including onset and course) of the Veteran's ear or peripheral vestibular 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: _____

3. Vestibular conditions

Does the Veteran have any of the following findings, signs or symptoms attributable to Meniere's syndrome (endolymphatic hydrops), a peripheral vestibular condition or another diagnosed condition from Section 1?

Yes No

If yes, check all that apply:

- Hearing impairment with vertigo
If checked, indicate frequency:
 Less than once a month 1 to 4 times per month More than once weekly
Indicate duration of episodes: <1 hour 1 to 24 hours >24 hours
- Hearing impairment with attacks of vertigo and cerebellar gait
If checked, indicate frequency:
 Less than once a month 1 to 4 times per month More than once weekly
Indicate duration of episodes: <1 hour 1 to 24 hours >24 hours
- Tinnitus, unilateral or bilateral
If checked, indicate frequency:
 Less than once a month 1 to 4 times per month More than once weekly
Indicate duration of episodes: <1 hour 1 to 24 hours >24 hours
- Vertigo
If checked, indicate frequency:
 Less than once a month 1 to 4 times per month More than once weekly
Indicate duration of episodes: <1 hour 1 to 24 hours >24 hours
- Staggering
If checked, indicate frequency:
 Less than once a month 1 to 4 times per month More than once weekly
Indicate duration of episodes: <1 hour 1 to 24 hours >24 hours
- Hearing impairment and/or tinnitus
If checked, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed.
- Other, describe: _____

4. Infectious, inflammatory and other ear conditions

a. Does the Veteran have any of the following findings, signs or symptoms attributable to chronic ear infection, inflammation, cholesteatoma or any of the diagnoses in Section 1?

Yes No

If yes, check all that apply:

- Swelling (external ear canal)
If checked, describe: _____
- Dry and scaly (external ear canal)
- Serous discharge (external ear canal)
- Itching (external ear canal)
- Effusion
- Active suppuration
- Aural polyps
- Hearing impairment and/or tinnitus
If checked, a Hearing Loss and Tinnitus Questionnaire must ALSO be completed.
- Facial nerve paralysis
If checked, ALSO complete Cranial Nerves Questionnaire.
- Bone loss of skull
If checked, indicate severity:
 Area lost smaller than an American quarter (4.619 cm²)
 Area lost larger than an American quarter but smaller than a 50-cent piece
 Area lost larger than an American 50-cent piece (7.355 cm²)

- Requiring frequent and prolonged treatment
If checked, describe type and durations of treatment: _____
- Other, describe: _____

b. Does the Veteran have a benign neoplasm of the ear (other than skin only, such as keloid) that causes any impairment of function?

- Yes No

If yes, describe impairment of function caused by this condition: _____

5. Surgical treatment

a. Has the Veteran had surgical treatment for any ear condition?

- Yes No

If yes, indicate type of surgery: _____

Date: _____

Side affected: Right Left Both

b. Does the Veteran have any residuals as a result of the surgery?

- Yes No

If yes, describe: _____

6. Physical exam

a. External ear

- Exam of external ear not indicated
- Normal
- Deformity of auricle, with loss of less than one-third of the substance
If checked, specify side: Right Left
- Deformity of auricle, with loss of one-third or more of the substance
If checked, specify side: Right Left
- Complete loss of auricle
If checked, specify side: Right Left
- Other abnormality, describe: _____

b. Ear canal:

- Exam of ear canal not indicated
- Normal
- Abnormal, describe: _____

c. Tympanic membrane:

- Exam of tympanic membrane not indicated
- Normal
- Perforated tympanic membrane
If checked, specify side affected: Right Left
- Evidence of a healed tympanic membrane perforation
If checked, specify side affected: Right Left
- Other abnormality, describe: _____

d. Gait:

- Exam of gait not indicated
- Normal
- Unsteady, describe: _____
- Other abnormality, describe: _____

e. Romberg test:

- Exam using this test not indicated
- Normal or negative
- Abnormal or positive for unsteadiness

- f. Dix Hallpike test (Nylen-Barany test) for vertigo
- Exam using this test not indicated
 - Normal, no vertigo or nystagmus during test
 - Abnormal, vertigo or nystagmus during test, describe: _____

- g. Limb coordination test (finger-nose-finger)
- Exam using this test not indicated
 - Normal
 - Abnormal, describe: _____

7. Tumors and neoplasms

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

- Yes No

If yes, complete the following:

b. Is the neoplasm

Benign Malignant

c. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?

- Yes No; watchful waiting

If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

Treatment completed; currently in watchful waiting status

Surgery

If checked, describe: _____

Date(s) of surgery: _____

Radiation therapy

Date of most recent treatment: _____

Date of completion of treatment or anticipated date of completion: _____

Antineoplastic chemotherapy

Date of most recent treatment: _____

Date of completion of treatment or anticipated date of completion: _____

Other therapeutic procedure

If checked, describe procedure: _____

Date of most recent procedure: _____

Other therapeutic treatment

If checked, describe treatment: _____

Date of completion of treatment or anticipated date of completion: _____

d. Does the Veteran currently have any residual conditions or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?

- Yes No

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

e. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the Diagnosis section, describe using the above format: _____

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

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 in the Diagnosis section above?

Yes No

If yes, describe (brief summary): _____

9. Diagnostic testing

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

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

Yes No

If yes, check all that apply:

- Magnetic resonance imaging (MRI)
Date: _____ Results: _____
- Computerized axial tomography (CT)
Date: _____ Results: _____
- Electronystagmography (ENG)
Date: _____ Results: _____
- Other, specify: _____
Date: _____ Results: _____

b. Has the Veteran had an audiogram?

Yes No

If yes, attach or provide results: _____

If the Veteran has hearing loss or tinnitus, a Hearing and Tinnitus exam must ALSO be scheduled.

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): _____

10. Functional impact

Do any of the Veteran's ear or peripheral vestibular conditions impact his or her ability to work?

Yes No

If yes, describe impact of each of the Veteran's ear or peripheral vestibular conditions, providing one or more examples: _____

11. Remarks, if any: _____

Physician signature: _____ Date: _____

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.4. DBQ Esophageal Conditions (including gastroesophageal reflux disease (GERD), hiatal hernia and other esophageal disorders)

Name of patient/Veteran: _____ SSN: _____

1. Diagnosis:

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

Yes No

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

<input type="checkbox"/> GERD	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Hiatal hernia	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Esophageal stricture	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Esophageal spasm	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Esophageal diverticulum	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Other esophageal condition (such as eosinophilic esophagitis, Barrett's esophagus, etc.)		

Other diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____

Other diagnosis #2: _____
ICD code: _____
Date of diagnosis: _____

If there are additional diagnoses that pertain to esophageal disorders, list using above format: _____

2. Medical history

a. Describe the history (including onset and course) of the Veteran's esophageal 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:

3. Signs and symptoms

Does the Veteran have any of the following signs or symptoms due to any esophageal conditions (including GERD)?

Yes No

If yes, check all that apply:

Persistently recurrent epigastric distress
 Infrequent episodes of epigastric distress
 Dysphagia

- Pyrosis (heartburn)
 Reflux
 Regurgitation
 Substernal arm or shoulder pain
 Sleep disturbance caused by esophageal reflux
 If checked, indicate frequency of symptom recurrence per year:
 1 2 3 4 or more
 If checked, indicate average duration of episodes of symptoms:
 Less than 1 day 1-9 days 10 days or more
- Anemia
 If checked, provide hemoglobin/hematocrit in diagnostic testing section.
- 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)
- Nausea
 If checked, indicate severity:
 Mild Transient Recurrent Periodic
 If checked, indicate frequency of episodes of nausea per year:
 1 2 3 4 or more
 If checked, indicate average duration of episodes of vomiting:
 Less than 1 day 1-9 days 10 days or more
- Vomiting
 If checked, indicate severity:
 Mild Transient Recurrent Periodic
 If checked, indicate frequency of episodes of vomiting per year:
 1 2 3 4 or more
 If checked, indicate average duration of episodes of vomiting:
 Less than 1 day 1-9 days 10 days or more
- Hematemesis
 If checked, indicate severity:
 Mild Transient Recurrent Periodic
 If checked, indicate frequency of episodes of hematemesis per year:
 1 2 3 4 or more
 If checked, indicate average duration of episodes of hematemesis:
 Less than 1 day 1-9 days 10 days or more
- Melena
 If checked, indicate severity:
 Mild Transient Recurrent Periodic
 If checked, indicate frequency of episodes of melena per year:
 1 2 3 4 or more
 If checked, indicate average duration of episodes of melena:
 Less than 1 day 1-9 days 10 days or more

4. Esophageal stricture, spasm and diverticula

Does the Veteran have an esophageal stricture, spasm of esophagus (cardiospasm or achalasia), or an acquired diverticulum of the esophagus?

Yes No

If yes, indicate severity of condition:

- Asymptomatic
 Not amenable to dilation
 Mild

If checked, describe: _____

Moderate

If checked, describe: _____
___ Severe, permitting passage of liquids only
If checked, describe: _____

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

___ Yes ___ No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

___ Yes ___ No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

___ Yes ___ No

If yes, describe (brief summary): _____

6. Diagnostic Testing

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

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

___ Yes ___ No

If yes, check all that apply:

___ Upper endoscopy

Date: _____ Results: _____

___ Upper GI radiographic studies

Date: _____ Results: _____

___ Esophagram (barium swallow)

Date: _____ Results: _____

___ MRI

Date: _____ Results: _____

___ CT

Date: _____ Results: _____

___ Biopsy, specify site: _____

Date: _____ Results: _____

___ Other, specify: _____

Date: _____ Results: _____

b. Has laboratory testing been performed?

___ Yes ___ No

If yes, check all that apply:

___ CBC Date of test: _____

Hemoglobin: _____ Hematocrit: _____

White blood cell count: _____ Platelets: _____

___ Helicobacter pylori

Date of test: _____ Results: _____

___ Other, specify: _____

Date of test: _____ 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):

7. Functional impact

Do any of the Veteran's esophageal conditions impact on his or her ability to work?

Yes No

If yes, describe impact of each of the Veteran's esophageal conditions, providing one or more examples: _____

8. Remarks, if any: _____

Physician signature: _____ Date: _____

Physician printed name: _____ Phone: _____

Medical license #: _____ FAX: _____

Physician address: _____

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 Gallbladder and Pancreas 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 a gallbladder or pancreas condition?

Yes No

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

- | | | |
|---|-----------------|--------------------------|
| <input type="checkbox"/> Chronic cholecystitis | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Chronic cholelithiasis | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Chronic cholangitis | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Cholecystectomy | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Pancreatitis | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Total or partial pancreatectomy | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Gallbladder neoplasm | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Pancreatic neoplasm | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Gallbladder or pancreas injury, with peritoneal adhesions resulting from this injury | ICD code: _____ | Date of diagnosis: _____ |

If checked, ALSO complete the Peritoneal Adhesions Questionnaire.

Other gallbladder conditions:

Other diagnosis #1: _____

ICD code: _____

Date of diagnosis: _____

Other diagnosis #2: _____

ICD code: _____

Date of diagnosis: _____

If there are additional diagnoses that pertain to gallbladder or pancreas conditions, list using above format: _____

2. Medical history

a. Describe the history (including onset and course) of the Veteran's gallbladder and/or pancreas conditions (brief summary): _____

b. Is continuous medication required for control of the Veteran's gallbladder or pancreas conditions?

Yes No

If yes, list only those medications required for the gallbladder or pancreas condition: _____

3. Gall bladder conditions: signs and symptoms

a. Does the Veteran have any of the following signs or symptoms attributable to any gallbladder conditions or residuals of treatment for gallbladder conditions?

Yes No

If yes, check all that apply:

- Gallbladder disease-induced dyspepsia (including sphincter of Oddi dysfunction and/or biliary dyskinesia)

If checked, indicate number of episodes per year: _____

- 0 1 2 3 4 or more
- Attacks of gallbladder colic
If checked, indicate number of attacks per year:
 0 1 2 3 4 or more
- Jaundice
If checked, provide bilirubin level in Diagnostic testing section.
- Other signs or symptoms, describe: _____

4. Pancreas conditions: signs and symptoms

a. Does the Veteran have any of the following symptoms attributable to any pancreas conditions or residuals of treatment for pancreas conditions?

- Yes No

If yes, check all that apply:

- Abdominal pain, confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies
If checked, indicate severity and frequency of attacks (check all that apply):
 Mild (typical) Moderately Severe Severe (disabling)
Indicate number of attacks of Mild (typical) abdominal pain in the past 12 months:
 0 1 2 3 4 5 6 7 8 or more
Indicate number of attacks of Moderately Severe abdominal pain in the past 12 months:
 0 1 2 3 4 5 6 7 8 or more
Indicate number of attacks of Severe (disabling) abdominal pain in the past 12 months:
 0 1 2 3 4 5 6 7 8 or more
- Remissions/pain-free intermissions between attacks
If checked, indicate characteristics of remissions:
 Good pain-free remissions between attacks
 Few pain-free intermissions between attacks
 Continuing pancreatic insufficiency between attacks
- Other symptoms, describe: _____

b. Does the Veteran have any of the following signs or findings attributable to any pancreas conditions or residuals of treatment for pancreas conditions?

- Yes No

If yes, check all that apply:

- Steatorrhea
If checked, describe frequency and severity: _____
- Malabsorption
If checked, describe frequency and severity: _____
- Diarrhea
If checked, describe frequency and severity: _____
- Severe malnutrition
If checked, describe deficiency (such as beta-carotene, fat-soluble vitamin deficiencies): _____
- 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: _____

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

- Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

- Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

Yes No

If yes, describe (brief summary): _____

6. Diagnostic testing

NOTE: Diagnosis of pancreatitis must be confirmed by appropriate laboratory and clinical studies. If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report.

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

Yes No

If yes, check all that apply:

EUS (Endoscopic ultrasound)

Date: _____ Results: _____

ERCP (Endoscopic retrograde cholangiopancreatography)

Date: _____ Results: _____

Transhepatic cholangiogram

Date: _____ Results: _____

MRI or MRCP (magnetic resonance cholangiopancreatography)

Date: _____ Results: _____

Gallbladder scan (HIDA scan or cholescintigraphy)

Date: _____ Results: _____

CT

Date: _____ Results: _____

Other, specify: _____

Date: _____ Results: _____

b. Has laboratory testing been performed?

Yes No

If yes, check all that apply:

Alkaline phosphatase Date: _____ Results: _____

Bilirubin Date: _____ Results: _____

WBC Date: _____ Results: _____

Amylase Date: _____ Results: _____

Lipase Date: _____ Results: _____

Other, specify: _____ 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): _____

7. Functional impact

Does the Veteran's gallbladder and/or pancreas condition(s) impact on his or her ability to work?

Yes No

If yes, describe the impact of each of the Veteran's gallbladder and/or pancreas conditions, 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. 6. DBQ Gynecological 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 she ever had a gynecological condition?

Yes No

If yes, provide only diagnoses that pertain to gynecological condition(s):

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 gynecological diagnoses, list using above format: _____

2. Medical history

Describe the history (including cause, onset and course) of each of the Veteran's gynecological conditions:

3. Symptoms

Does the Veteran currently have symptoms related to a gynecological condition, including any diseases, injuries or adhesions of the female reproductive organs?

Yes No

If yes, indicate current symptoms, including frequency and severity of pain, if any: (check all that apply)

Intermittent pain

Constant pain

Mild pain

Moderate pain

Severe pain

Pelvic pressure

Irregular menstruation

Frequent or continuous menstrual disturbances

Other signs and/or symptoms describe and indicate condition(s) causing them: _____

4. Treatment

a. Has the Veteran had treatment for symptoms/findings for any diseases, injuries and/or adhesions of the reproductive organs?

Yes No

If yes, specify condition(s), organ(s) affected, and treatment: _____

Date of treatment: _____

b. Does the Veteran currently require treatment or medications [for symptoms?] related to reproductive tract conditions?

Yes No

If yes, list current treatment/medications and the reproductive organ condition(s) being treated: _____

c. If yes, indicate effectiveness of treatment in controlling symptoms:

Symptoms do not require continuous treatment for the following organ/condition: _____

Symptoms require continuous treatment for the following organ/condition: _____

Symptoms are not controlled by continuous treatment: for the following organ/condition: _____

5. Conditions of the vulva

Has the Veteran been diagnosed with any diseases, injuries or other conditions of the vulva (to include vulvovaginitis)?

Yes No

If yes, describe: _____

6. Conditions of the vagina

Has the Veteran been diagnosed with any diseases, injuries or other conditions of the vagina?

Yes No

If yes, describe: _____

7. Conditions of the cervix

Has the Veteran been diagnosed with any diseases, injuries, adhesions or other conditions of the cervix?

Yes No

If yes, describe: _____

8. Conditions of the uterus

a. Has the Veteran been diagnosed with any diseases, injuries, adhesions or other conditions of the uterus?

Yes No

b. Has the Veteran had a hysterectomy?

Yes No

If yes, provide date(s) of surgery, facility(ies) where performed, and cause: _____

c. Does the Veteran have uterine prolapse?

Yes No

If yes, indicate severity:

Incomplete

Complete (through vagina and introitus)

If yes, does the condition currently cause symptoms?

Yes No

If yes, describe: _____

d. Does the Veteran have uterine fibroids, enlargement of the uterus and/or displacement of the uterus?

Yes No

If yes, are there signs and symptoms?

Yes No

If yes, check all that apply :

Adhesions

Marked displacement: If checked, indicate cause _____

Marked enlargement: If checked, indicate cause: _____

Uterine fibroids

Irregular menstruation: If checked, indicate cause: _____

Frequent or continuous menstrual disturbances: If checked, indicate cause: _____

Other, describe and indicate cause: _____

e. Has the Veteran been diagnosed with any other diseases, injuries, adhesions or other conditions of the uterus?
 Yes No
If yes, describe: _____

9. Conditions of the Fallopian tubes

Has the Veteran been diagnosed with any diseases, injuries, adhesions or other conditions of the Fallopian tubes (to include pelvic inflammatory disease)?
 Yes No
If yes, describe: _____

10. Conditions of the ovaries

a. Has the Veteran undergone menopause?

- Yes No
If yes, indicate:
 Natural menopause
 Premature menopause
 Surgical menopause
 Chemical-induced menopause
 Radiation-induced menopause

b. Has the Veteran undergone partial or complete oophorectomy?

- Yes No
If yes, check all that apply:
 Partial removal of an ovary
 Right Left Both
 Complete removal of an ovary
 Right Left Both

If yes, provide date(s) of surgery, facility(ies) where performed, and reason for surgery: _____

c. Does the Veteran have evidence of complete atrophy of 1 or both ovaries?

- Yes No Unknown
If yes, etiology: _____

- If yes, indicate severity:
 Partial atrophy of 1 or both ovaries
 Complete atrophy of 1 ovary
 Complete atrophy of both ovaries (excluding natural menopause)

d. Has the Veteran been diagnosed with any other diseases, injuries, adhesions and/or other conditions of the ovaries?

- Yes No
If yes, describe: _____

11. Incontinence

Does the Veteran have urinary incontinence/leakage?

- Yes No
If yes, is the urinary incontinence/leakage due to a gynecologic condition?
 Yes No

If yes, condition causing it: _____

- If yes, check all that apply:
 Does not require/does not use absorbent material
 Stress incontinence
 Requires absorbent material that is changed less than 2 times per day
 Requires absorbent material that is changed 2 to 4 times per day
 Requires absorbent material that is changed more than 4 times per day
 Requires the use of an appliance

If checked, describe appliance: _____

12. Fistulae

a. Does the Veteran have a rectovaginal fistula?

Yes No

If yes, cause: _____

If yes, does the Veteran have vaginal-fecal leakage?

Yes No

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

- Less than once a week
- 1-3 times per week
- 4 or more times per week
- Daily or more often
- Requires wearing of pad or absorbent material

b. Does the Veteran have a urethrovaginal fistula?

Yes No

If yes, cause: _____

If yes, does the Veteran have urine leakage?

Yes No

If yes, check all that apply:

- Does not require/does not use absorbent material
 - Requires absorbent material that is changed less than 2 times per day
 - Requires absorbent material that is changed 2 to 4 times per day
 - Requires absorbent material that is changed more than 4 times per day
 - Requires the use of an appliance
- If checked, describe appliance: _____

13. Endometriosis

Has the Veteran been diagnosed with endometriosis?

NOTE: A diagnosis of endometriosis must be substantiated by laparoscopy.

Yes No

If yes, does the Veteran currently have any findings, signs or symptoms due to endometriosis?

Yes No

If yes, check all that apply:

- Pelvic pain
- Heavy or irregular bleeding requiring continuous treatment for control
- Heavy or irregular bleeding not controlled by treatment
- Lesions involving bowel or bladder confirmed by laparoscopy
- Bowel or bladder symptoms from endometriosis
- Anemia caused by endometriosis
- Other, describe: _____

14. Complications and residuals of pregnancy or other gynecologic procedures

a. Has the Veteran had any surgical complications of pregnancy?

Yes No

If yes, check all that apply:

- Relaxation of perineum
- Rectocele
- Cystocele
- Other, describe: _____

b. Has the Veteran had any other complications resulting from obstetrical or gynecologic conditions or procedures?

Yes No

If yes, describe: _____

NOTE: If obstetrical or gynecologic complications impact other body systems, also complete the additional appropriate Questionnaire(s).

15. Tumors and neoplasms

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

Yes No

If yes, complete the following:

b. Is the neoplasm

Benign Malignant

c. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?

Yes No; watchful waiting

If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

Treatment completed; currently in watchful waiting status

Surgery

If checked, describe: _____

Date(s) of surgery: _____

Radiation therapy

Date of most recent treatment: _____

Date of completion of treatment or anticipated date of completion: _____

Antineoplastic chemotherapy

Date of most recent treatment: _____

Date of completion of treatment or anticipated date of completion: _____

Other therapeutic procedure

If checked, describe procedure: _____

Date of most recent procedure: _____

Other therapeutic treatment

If checked, describe treatment: _____

Date of completion of treatment or anticipated date of completion: _____

d. Does the Veteran currently have any residual conditions or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?

Yes No

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

e. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the Diagnosis section, describe using the above format: _____

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

Yes No

If yes, describe (brief summary): _____

17. Diagnostic testing

NOTE: If laboratory test results are in the medical record and reflect the Veteran's current condition, repeat testing is not required.

a. Has the Veteran had laparoscopy?

Yes No

If yes, provide date(s) and facility where performed, and results: _____

b. Has the Veteran been diagnosed with anemia?

Yes No

If yes, provide most recent test results:

Hgb: _____

Hct: _____

Date of test: _____

c. Has the Veteran had any other 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): _____

18. Functional impact

Does the Veteran's gynecological condition(s) impact her ability to work?

Yes No

If yes, describe impact of each of the Veteran's gynecological conditions, providing one or more examples: ____

19. 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 Headaches (including Migraine Headaches)

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 headache condition?

Yes No

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

- | | | |
|--|----------------|-------------------------|
| <input type="checkbox"/> Migraine including migraine variants | ICD code: ____ | Date of diagnosis: ____ |
| <input type="checkbox"/> Tension | ICD code: ____ | Date of diagnosis: ____ |
| <input type="checkbox"/> Cluster | ICD code: ____ | Date of diagnosis: ____ |
| <input type="checkbox"/> Other (specify type of headache): _____ | ICD code: ____ | Date of diagnosis: ____ |

Other diagnosis #1: _____

ICD code: _____

Date of diagnosis: _____

Other diagnosis #2: _____

ICD code: _____

Date of diagnosis: _____

If there are additional diagnoses that pertain to a headache condition, list using above format: _____

2. Medical History

a. Describe the history (including onset and course) of the Veteran's headache conditions (brief summary): _____

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

Yes No

If yes, describe treatment (list only those medications used for the diagnosed condition):

3. Symptoms

a. Does the Veteran experience headache pain?

Yes No

If yes, check all that apply to headache pain:

- Constant head pain
- Pulsating or throbbing head pain
- Pain localized to one side of the head
- Pain on both sides of the head
- Pain worsens with physical activity
- Other, describe: _____

b. Does the Veteran experience non-headache symptoms associated with headaches? (including symptoms associated with an aura prior to headache pain)

Yes No

If yes, check all that apply:

- Nausea
- Vomiting
- Sensitivity to light
- Sensitivity to sound
- Changes in vision (such as scotoma, flashes of light, tunnel vision)
- Sensory changes (such as feeling of pins and needles in extremities)
- Other, describe: _____

c. Indicate duration of typical head pain

- Less than 1 day
- 1-2 days
- More than 2 days
- Other, describe: _____

d. Indicate location of typical head pain

- Right side of head
- Left side of head
- Both sides of head
- Other, describe: _____

4. Prostrating attacks of headache pain

a. Migraine - Does the Veteran have characteristic prostrating attacks of migraine headache pain?

- Yes No

If yes, indicate frequency, on average, of prostrating attacks over the last several months:

- Less than once every 2 months
- Once in 2 months
- Once every month
- More frequently than once per month

b. Does the Veteran have very frequent prostrating and prolonged attacks of migraine headache pain?

- Yes No

c. Non-Migraine - Does the Veteran have prostrating attacks of non-migraine headache pain?

- Yes No

If yes, indicate frequency, on average, of prostrating attacks over the last several months:

- Less than once every 2 months
- Once in 2 months
- Once every month
- More frequently than once per month

d. Does the Veteran have very frequent prostrating and prolonged attacks of non-migraine headache pain?

- Yes No

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

- Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

- Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

Yes No

If yes, describe (brief summary): _____

6. Diagnostic testing

NOTE: Diagnostic testing is not required for this examination report; if studies have already been completed, provide the most recent results below.

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 headache condition impact his or her ability to work?

Yes No

If yes, describe impact of the Veteran's headache condition, 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.

6.8. DBQ Infectious Intestinal Disorders, Including bacterial and parasitic infections

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 intestinal condition?

Yes No

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

- | | | |
|--|-----------------|--------------------------|
| <input type="checkbox"/> Bacillary dysentery | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Intestinal distomiasis (intestinal fluke) | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Parasitic infection of the intestines | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Amebiasis | ICD code: _____ | Date of diagnosis: _____ |

If the Veteran has a lung abscess due to amebiasis, ALSO complete the Respiratory Questionnaire.

Other infectious intestinal 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 infectious intestinal conditions, list using above format: _____

2. Medical History

a. Describe the history (including onset, course, and past treatment) of the Veteran's infectious intestinal conditions (brief summary): _____

b. Is continuous medication required for control of the Veteran's intestinal conditions?

Yes No

If yes, list only those medications required for the intestinal conditions: _____

c. Has the Veteran had surgical treatment for an intestinal condition?

Yes No

If yes, ALSO complete the Intestinal Surgery Questionnaire.

3. Signs and symptoms

Does the Veteran have any signs or symptoms attributable to any infectious intestinal conditions?

Yes No

If yes, check all that apply:

Mild symptoms attributable to distomiasis, intestinal or hepatic

If checked, describe: _____

Moderate symptoms attributable to distomiasis, intestinal or hepatic

If checked, describe: _____

- Severe symptoms attributable to distomiasis, intestinal or hepatic
If checked, describe: _____
- Mild gastrointestinal disturbances
If checked, describe: _____
- Lower abdominal cramps
If checked, describe: _____
- Gaseous distention
If checked, describe: _____
- Chronic constipation interrupted by diarrhea
If checked, describe: _____
- Anemia
If checked, provide hemoglobin/hematocrit in Diagnostic testing section.
- Nausea
If checked, describe: _____
- Vomiting
If checked, describe: _____
- Other, describe: _____

Note: Complete the appropriate Disability Questionnaire(s) when the infectious disease affects other organs such as the liver, lung, kidney, etc. (schedule with appropriate provider)

4. Symptom episodes, attacks and exacerbations

Does the Veteran have episodes of bowel disturbance with abdominal distress, or exacerbations or attacks of the intestinal condition?

- Yes No

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

- Episodes of bowel disturbance with abdominal distress

If checked, indicate frequency:

- Occasional episodes
- Frequent episodes
- More or less constant abdominal distress
- Episodes of exacerbations and/or attacks of the intestinal condition

If checked, describe typical exacerbation or attack: _____

Indicate number of exacerbations and/or attacks in past 12 months:

- 0 1 2 3 4 5 6 7 or more

5. Weight loss

Does the Veteran have weight loss attributable to an infectious intestinal condition?

- Yes No

If yes, provide Veteran's baseline weight: _____ and current weight: _____

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

6. Malnutrition, complications and other general health effects

Does the Veteran have malnutrition, serious complications or other general health effects attributable to the intestinal condition?

- Yes No

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

- Health only fair during remissions
- Resulting in general debility
- Resulting in serious complication such as liver abscess
- Malnutrition

If checked, is malnutrition marked? Yes No

- Other, describe: _____

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

Yes No

If yes, describe (brief summary): _____

8. Diagnostic testing

NOTE: If imaging studies, diagnostic procedures or laboratory testing has been performed and reflects the Veteran's current condition, provide most recent results; no further studies or testing are required for this examination.

a. Has laboratory testing been performed?

Yes No

If yes, check all that apply:

CBC (if anemia due to any intestinal condition is suspected or present)

Date of test: _____

Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____

Other, 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. 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

Do any of the Veteran's infectious intestinal conditions impact his or her ability to work?

Yes No

If yes, describe the impact of each of the Veteran's infectious intestinal 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.

6.9. DBQ Intestinal Surgery (bowel resection, colostomy and ileostomy)

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

Has the Veteran had intestinal surgery?

Yes No

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

Resection of the small intestine
ICD code: _____ Date of diagnosis: _____ Reason for surgery: _____

Resection of the large intestine
ICD code: _____ Date of diagnosis: _____ Reason for surgery: _____

Peritoneal adhesions attributable to resection of the large or small intestine
If checked, ALSO complete the Peritoneal Adhesions Questionnaire.
ICD code: _____ Date of diagnosis: _____ Reason for surgery: _____

Persistent fistula ICD code: _____ Date of diagnosis: _____ Reason for surgery: _____

Other intestinal surgery, specify diagnoses below, providing only diagnoses that pertain to intestinal surgery:

Other diagnosis #1: _____

ICD code: _____

Date of diagnosis: _____

Reason for surgery: _____

Other diagnosis #2: _____

ICD code: _____

Date of diagnosis: _____

Reason for surgery: _____

If there are additional diagnoses that pertain to intestinal surgery, list using above format: _____

2. Medical History

a. Describe the history (including onset and course) of the Veteran's intestinal surgery (brief summary): _____

b. Is continuous medication required for control of the Veteran's intestinal conditions?

Yes No

If yes, list only those medications required for the intestinal conditions: _____

3. Signs and symptoms

Does the Veteran have any signs or symptoms attributable to any intestinal surgery?

Yes No

If yes, check all that apply:

Slight symptoms attributable to resection of large intestine

If checked, describe: _____

Moderate symptoms attributable to resection of large intestine

If checked, describe: _____

Severe symptoms, objectively supported by examination findings, attributable to resection of large intestine

If checked, describe: _____

- Abdominal pain and/or colic pain
If checked, describe: _____
- Diarrhea
If checked, describe: _____
- Alternating diarrhea and constipation
If checked, describe: _____
- Abdominal distension
If checked, describe: _____
- Anemia
If checked, provide hemoglobin/hematocrit in Diagnostic testing section.
- Nausea
If checked, describe: _____
- Vomiting
If checked, describe: _____
- Pulling pain on attempting work or aggravated by movements of the body
- Other, describe: _____

4. Weight loss

Does the Veteran have weight loss or inability to gain weight attributable to intestinal surgery?

- Yes No

If yes, complete the following section:

a. Provide Veteran's baseline weight: _____ and current weight: _____
(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

b. Has the Veteran's weight loss been sustained for 3 months or longer?

- Yes No

c. Has the Veteran been unable to regain weight despite appropriate therapy?

- Yes No

5. Absorption and nutrition

Does the Veteran have any interference with absorption and nutrition attributable to resection of the small intestine?

- Yes No not applicable

If yes, does this cause impairment of health objectively supported by examination findings including definite and/or material weight loss?

- Yes No

If yes, is impairment of health severe?

- Yes No

Indicate severity of interference with absorption and nutrition: Definite Marked

6. Ostomy

Did the Veteran's intestinal condition require an ileostomy or colostomy?

- Yes No

If yes, describe: _____

7. Fistula

Does the Veteran now have or has he or she ever had a persistent intestinal fistula attributable to a surgical intestinal condition?

- Yes No

If yes, does the Veteran have fecal discharge attributable to this?

- Yes No

If yes, indicate the severity and frequency of fecal discharge (check all that apply):

- Slight
- Copious

- Infrequent
- Frequent
- Constant
- Other, describe: _____

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

- Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

- Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs 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, no further studies or testing are required for this examination.

a. Has laboratory testing been performed?

- Yes No

If yes, check all that apply:

- CBC (if anemia due to any intestinal condition is suspected or present)

Date of test: _____

Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____

- Other, 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. 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 intestinal surgery residuals impact his or her ability to work?

- Yes No

If yes, describe the impact of each of the Veteran's intestinal surgery residuals, including any ongoing symptoms of original cause of surgery that may be hard to distinguish from post-surgical residuals, 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.

6.10. DBQ Intestinal Conditions (other than Surgical or Infectious), including irritable bowel syndrome, Crohn's disease, ulcerative colitis and diverticulitis

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 intestinal condition (other than surgical or infectious)?

Yes No

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

- Irritable bowel syndrome ICD code: _____ Date of diagnosis: _____
- Spastic colitis ICD code: _____ Date of diagnosis: _____
- Mucous colitis ICD code: _____ Date of diagnosis: _____
- Chronic diarrhea ICD code: _____ Date of diagnosis: _____
- Ulcerative colitis ICD code: _____ Date of diagnosis: _____
- Crohn's disease ICD code: _____ Date of diagnosis: _____
- Chronic enteritis ICD code: _____ Date of diagnosis: _____
- Chronic enterocolitis ICD code: _____ Date of diagnosis: _____
- Celiac disease ICD code: _____ Date of diagnosis: _____
- Diverticulitis ICD code: _____ Date of diagnosis: _____
- Intestinal neoplasm ICD code: _____ Date of diagnosis: _____

Peritoneal adhesions attributable to diverticulitis

If checked, ALSO complete the Peritoneal Adhesions Questionnaire.

ICD code: _____ Date of diagnosis: _____

Other non-surgical or non-infectious intestinal conditions:

Other diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____

Other diagnosis #2: _____
ICD code: _____
Date of diagnosis: _____

If there are additional diagnoses that pertain to intestinal conditions (other than surgical or infectious), list using above format: _____

2. Medical history

a. Describe the history (including onset and course) of the Veteran's intestinal condition (brief summary): _____

b. Is continuous medication required for control of the Veteran's intestinal condition?

Yes No

If yes, list only those medications required for the intestinal condition: _____

c. Has the Veteran had surgical treatment for an intestinal condition?

Yes No

If yes, ALSO complete the Intestinal Surgery Questionnaire.

3. Signs and symptoms

Does the Veteran have any signs or symptoms attributable to any non-surgical non-infectious intestinal conditions?

Yes No

If yes, check all that apply:

Diarrhea

If checked, describe: _____

Alternating diarrhea and constipation

If checked, describe: _____

Abdominal distension

If checked, describe: _____

Anemia

If checked, provide hemoglobin/hematocrit in Diagnostic testing section.

Nausea

If checked, describe: _____

Vomiting

If checked, describe: _____

Other, describe: _____

4. Symptom episodes, attacks and exacerbations

Does the Veteran have episodes of bowel disturbance with abdominal distress, or exacerbations or attacks of the intestinal condition?

Yes No

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

Episodes of bowel disturbance with abdominal distress

If checked, indicate frequency:

Occasional episodes

Frequent episodes

More or less constant abdominal distress

Episodes of exacerbations and/or attacks of the intestinal condition

If checked, describe typical exacerbation or attack: _____

Indicate number of exacerbations and/or attacks in past 12 months:

0 1 2 3 4 5 6 7 or more

5. Weight loss

Does the Veteran have weight loss attributable to an intestinal condition (other than surgical or infectious condition)?

Yes No

If yes, provide Veteran's baseline weight: _____ and current weight: _____

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

6. Malnutrition, complications and other general health effects

Does the Veteran have malnutrition, serious complications or other general health effects attributable to the intestinal condition?

Yes No

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

Health only fair during remissions

General debility

Serious complication such as liver abscess, describe: _____

Malnutrition

If checked, is malnutrition marked? Yes No

Other, describe: _____

Note: Complete additional Disability Questionnaire(s) for complications noted, as deemed appropriate (schedule with appropriate provider)

7. Tumors and neoplasms

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

Yes No

If yes, complete the following:

b. Is the neoplasm

Benign Malignant

c. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?

Yes No; watchful waiting

If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

Treatment completed; currently in watchful waiting status

Surgery

If checked, describe: _____

Date(s) of surgery: _____

Radiation therapy

Date of most recent treatment: _____

Date of completion of treatment or anticipated date of completion: _____

Antineoplastic chemotherapy

Date of most recent treatment: _____

Date of completion of treatment or anticipated date of completion: _____

Other therapeutic procedure

If checked, describe procedure: _____

Date of most recent procedure: _____

Other therapeutic treatment

If checked, describe treatment: _____

Date of completion of treatment or anticipated date of completion: _____

d. Does the Veteran currently have any residual conditions or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?

Yes No

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

e. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the Diagnosis section, describe using the above format: _____

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

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

Yes No

If yes, describe (brief summary): _____

b. 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.

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 testing are required for this examination.

a. Has laboratory testing been performed?

Yes No

If yes, check all that apply:

CBC (if anemia due to any intestinal condition is suspected or present)

Date of test: _____

Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____

Other, 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. 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 intestinal condition impact his or her ability to work?

Yes No

If yes, describe the impact of each of the Veteran's intestinal 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.

6.11. DBQ Hepatitis, Cirrhosis and other Liver 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 a liver condition?

Yes No

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

- | | | | |
|---|-----------------|--------------------------|------------------------|
| <input type="checkbox"/> Hepatitis A | ICD code: _____ | Date of diagnosis: _____ | (complete Section I) |
| <input type="checkbox"/> Hepatitis B | ICD code: _____ | Date of diagnosis: _____ | (complete Section I) |
| <input type="checkbox"/> Hepatitis C | ICD code: _____ | Date of diagnosis: _____ | (complete Section I) |
| <input type="checkbox"/> Autoimmune hepatitis | ICD code: _____ | Date of diagnosis: _____ | (complete Section I) |
| <input type="checkbox"/> Drug-induced hepatitis | ICD code: _____ | Date of diagnosis: _____ | (complete Section I) |
| <input type="checkbox"/> Hemochromatosis | ICD code: _____ | Date of diagnosis: _____ | (complete Section I) |
| <input type="checkbox"/> Cirrhosis of the liver | ICD code: _____ | Date of diagnosis: _____ | (complete Section II) |
| <input type="checkbox"/> Primary biliary cirrhosis | ICD code: _____ | Date of diagnosis: _____ | (complete Section II) |
| <input type="checkbox"/> Sclerosing cholangitis | ICD code: _____ | Date of diagnosis: _____ | (complete Section II) |
| <input type="checkbox"/> Liver transplant candidate | ICD code: _____ | Date of diagnosis: _____ | (complete Section III) |
| <input type="checkbox"/> Liver transplant | ICD code: _____ | Date of diagnosis: _____ | (complete Section III) |
| <input type="checkbox"/> Other liver conditions: | | | |

Other diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____

Other diagnosis #2: _____
ICD code: _____
Date of diagnosis: _____

If there are additional diagnoses that pertain to liver conditions, list using above format: _____

NOTE: Determination of these conditions requires documentation by appropriate serologic testing, abnormal liver function tests, and/or abnormal liver biopsy or imaging tests. If test results are documented in the medical record, additional testing is not required.

2. Medical History

a. Describe the history (including cause, onset and course) of the Veteran's liver conditions (brief summary):

b. Is continuous medication required for control of the Veteran's liver conditions?

Yes No

If yes, list only those medications required for the liver conditions: _____

SECTION I: Hepatitis (including hepatitis A, B and C, autoimmune or drug-induced hepatitis, any other infectious liver disease and chronic liver disease without cirrhosis)

a. Does the Veteran currently have signs or symptoms attributable to chronic or infectious liver diseases?

Yes No

If yes, indicate signs and symptoms attributable to chronic or infectious liver diseases (check all that apply):

Fatigue

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Malaise

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Anorexia

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Nausea

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Vomiting

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Arthralgia

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

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)

Also, indicate if this weight loss has been sustained for three months or longer: Yes No

Right upper quadrant pain

If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating

Hepatomegaly

Condition requires dietary restriction

If checked, describe dietary restrictions: _____

Condition results in other indications of malnutrition

If checked, describe other indications of malnutrition: _____

Other, describe: _____

c. Has the Veteran been diagnosed with hepatitis C?

Yes No

If yes, indicate risk factors (check all that apply):

Unknown

No known risk factors

Organ transplant before 1992

Transfusions of blood or blood products before 1992

Hemodialysis

Accidental exposure to blood by health care workers (to include combat medic or corpsman)

Intravenous drug use or intranasal cocaine use

High risk sexual activity

Other direct percutaneous exposure to blood (such as by tattooing, body piercing, acupuncture with non-sterile needles, shared toothbrushes and/or shaving razors)

If checked, describe: _____

Other, describe: _____

d. Has the Veteran had any incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) due to the liver conditions during the past 12 months?

Yes No

If yes, provide the total duration of the incapacitating episodes over the past 12 months:

- Less than 1 week
- At least 1 week but less than 2 weeks
- At least 2 weeks but less than 4 weeks
- At least 4 weeks but less than 6 weeks
- 6 weeks or more

NOTE: For VA purposes, an incapacitating episode means a period of acute symptoms severe enough to require bed rest and treatment by a physician.

SECTION II: Cirrhosis of the liver, biliary cirrhosis and cirrhotic phase of sclerosing cholangitis

Does the Veteran currently have signs or symptoms attributable to cirrhosis of the liver, biliary cirrhosis or cirrhotic phase of sclerosing cholangitis?

Yes No

If yes, indicate signs and symptoms attributable to cirrhosis of the liver, biliary cirrhosis or cirrhotic phase of sclerosing cholangitis (check all that apply):

- Weakness
If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating
- Anorexia
If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating
- Abdominal pain
If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating
- Malaise
If checked, indicate frequency and severity: Intermittent Daily Near-constant and debilitating
- 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)
Also, indicate if this weight loss has been sustained for three months or longer: Yes No
- Ascites
If checked, indicate frequency and severity: (check all that apply)
 1 episode 2 or more episodes Periods of remission between attacks Refractory to treatment
Date of last episode of ascites: _____
- Hepatic encephalopathy
If checked, indicate frequency and severity: (check all that apply)
 1 episode 2 or more episodes Periods of remission between attacks Refractory to treatment
Date of last episode of hepatic encephalopathy: _____
- Hemorrhage from varices or portal gastropathy (erosive gastritis)
If checked, indicate frequency and severity: (check all that apply)
 1 episode 2 or more episodes Periods of remission between attacks Refractory to treatment
Date of last episode of hemorrhage from varices or portal gastropathy: _____
- Portal hypertension
- Splenomegaly
- Persistent jaundice

SECTION III: Liver transplant and/or liver injury

a. Is the Veteran a liver transplant candidate?

Yes No

b. Is the Veteran currently hospitalized awaiting transplant?

Yes No

Date of hospital admission for this condition: _____

c. Has the Veteran undergone a liver transplant?

Yes No

Date(s) of surgery: _____

Date of hospital discharge: _____

Current signs and symptoms _____

d. Has the Veteran had an injury to the liver?

Yes No

If yes, does the Veteran have peritoneal adhesions resulting from an injury to the liver?

Yes No

If yes, ALSO complete the Peritoneal Adhesions Questionnaire.

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

Yes No

If yes, describe (brief summary): _____

4. Diagnostic testing

NOTE: Diagnosis of hepatitis C must be confirmed by recombinant immunoblot assay (RIBA). If this information is of record, repeat RIBA test is not required.

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

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

Yes No

If yes, check all that apply:

EUS (Endoscopic ultrasound)

Date: _____ Results: _____

ERCP (Endoscopic retrograde cholangiopancreatography)

Date: _____ Results: _____

Transhepatic cholangiogram

Date: _____ Results: _____

MRI or MRCP (magnetic resonance cholangiopancreatography)

Date: _____ Results: _____

CT

Date: _____ Results: _____

Other, describe: _____ Date: _____ Results: _____

b. Have laboratory studies been performed?

Yes No

If yes, check all that apply:

- | | | |
|--|-------------|----------------|
| <input type="checkbox"/> Recombinant immunoblot assay (RIBA) | Date: _____ | Results: _____ |
| <input type="checkbox"/> Hepatitis C genotype | Date: _____ | Results: _____ |
| <input type="checkbox"/> Hepatitis C viral titers | Date: _____ | Results: _____ |
| <input type="checkbox"/> AST | Date: _____ | Results: _____ |
| <input type="checkbox"/> ALT | Date: _____ | Results: _____ |
| <input type="checkbox"/> Alkaline phosphatase | Date: _____ | Results: _____ |
| <input type="checkbox"/> Bilirubin | Date: _____ | Results: _____ |
| <input type="checkbox"/> INR (PT) | Date: _____ | Results: _____ |
| <input type="checkbox"/> Creatinine | Date: _____ | Results: _____ |
| <input type="checkbox"/> MELD score | Date: _____ | Results: _____ |
| <input type="checkbox"/> Other, describe: | Date: _____ | Results: _____ |

c. Has a liver biopsy been performed?

Yes No Date of test: _____ 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): _____

5. Functional impact

Does the Veteran's liver condition impact his or her ability to work?

Yes No

If yes, describe the impact of each of the Veteran's liver conditions, 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.

6.12. DBQ Multiple Sclerosis (MS)

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 multiple sclerosis (MS)?

Yes No

If yes, provide only diagnoses that pertain to MS:

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 MS, list using above format: _____

2. Medical history

a. Describe the history (including onset and course) of the Veteran's MS (brief summary): _____

b. Dominant hand

Right Left Ambidextrous

3. Conditions, signs and symptoms due to MS

a. Does the Veteran have any muscle weakness in the upper and/or lower extremities attributable to MS?

Yes No

If yes, report under strength testing in neurologic exam section.

b. Does the Veteran have any pharynx and/or larynx and/or swallowing conditions due to MS?

Yes No

If yes, check all that apply:

Constant inability to communicate by speech

Speech not intelligible or individual is aphonic

Paralysis of soft palate with swallowing difficulty (nasal

- regurgitation) and speech impairment
- Hoarseness
- Mild swallowing difficulties
- Moderate swallowing difficulties
- Severe swallowing difficulties, permitting passage of liquids only
- Requires feeding tube due to swallowing difficulties
- Other, describe: _____

c. Does the Veteran have any respiratory conditions attributable to MS?

Yes No

If yes, provide PFT results under "Diagnostic testing" section and complete Respiratory Questionnaire (DBQ).

d. Does the Veteran have sleep disturbances attributable to MS?

Yes No

If yes, check all that apply:

- Insomnia
- Hypersomnolence and/or daytime "sleep attacks"
- Persistent daytime hypersomnolence
- Sleep apnea requiring the use of breathing assistance device such as continuous airway pressure (CPAP) machine
- Sleep apnea causing chronic respiratory failure with carbon dioxide retention or cor pulmonale
- Sleep apnea requiring tracheostomy

e. Does the Veteran have any bowel functional impairment attributable to MS?

Yes No

If yes, check all that apply:

- Slight impairment of sphincter control, without leakage
- Constant slight leakage
- Occasional moderate leakage
- Occasional involuntary bowel movements, necessitating wearing of a pad
- Extensive leakage and fairly frequent involuntary bowel movements
- Total loss of bowel sphincter control
- Chronic constipation
- Other bowel impairment (describe): _____

f. Does the Veteran have voiding dysfunction causing urine leakage attributable to MS?

Yes No

If yes, check all that apply:

- Does not require/does not use absorbent material
- Requires absorbent material that is changed less than 2 times per day
- Requires absorbent material that is changed 2 to 4 times per day
- Requires absorbent material that is changed more than 4 times per day

g. Does the Veteran have voiding dysfunction causing urinary frequency attributable to MS?

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

h. Does the Veteran have voiding dysfunction causing obstructed voiding attributable to MS?

Yes No

If yes, check all signs and symptoms 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 or continuous catheterization

i. Does the Veteran have voiding dysfunction requiring the use of an appliance attributable to MS?

Yes No

If yes, describe: _____

j. Does the Veteran have a history of recurrent symptomatic urinary tract infections attributable to MS?

Yes No

If yes, check all treatments that apply:

No treatment

Long-term drug therapy

If checked, list medications used for urinary tract infection and indicate dates for courses of treatment over the past 12 months: _____

Hospitalization

If checked, indicate frequency of hospitalization:

1 or 2 per year

More than 2 per year

Drainage

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

Other management/treatment not listed above

Description of management/treatment including dates of treatment: _____

k. Does the Veteran (if male) have erectile dysfunction attributable to MS?

Yes No

If yes, is the Veteran able to achieve an erection (without medication) sufficient for penetration and ejaculation?

Yes No

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

Yes No

I. Visual disturbances

Does the Veteran have any visual disturbances attributable to MS?

Yes No

If yes, check all that apply, and also complete Eye Questionnaire (schedule with appropriate examiner):

Diplopia

Blurring of vision

Internuclear ophthalmoplegia

Decreased visual acuity

If checked, specify: unilateral bilateral

Visual scotoma

If checked, specify: unilateral bilateral

Nystagmus

Optic neuritis

Other, describe: _____

4. Neurologic exam

a. Gait

Normal Abnormal, describe: _____

If gait is abnormal, and the Veteran has more than one medical condition contributing to the abnormal gait, identify the conditions and describe each condition's contribution to the abnormal gait: _____

b. Strength

Rate strength according to the following scale:

0/5 No muscle movement

1/5 Visible muscle movement, but no joint movement

2/5 No movement against gravity

3/5 No movement against resistance

4/5 Less than normal strength

5/5 Normal strength

All Normal

Shoulder extension:

Right: 5/5 4/5 3/5 2/5 1/5 0/5

Left: 5/5 4/5 3/5 2/5 1/5 0/5

Shoulder flexion:

Right: 5/5 4/5 3/5 2/5 1/5 0/5

Left: 5/5 4/5 3/5 2/5 1/5 0/5

Elbow flexion:

Right: 5/5 4/5 3/5 2/5 1/5 0/5

Left: 5/5 4/5 3/5 2/5 1/5 0/5

Elbow extension:

Right: 5/5 4/5 3/5 2/5 1/5 0/5

Left: 5/5 4/5 3/5 2/5 1/5 0/5

Wrist flexion:

Right: 5/5 4/5 3/5 2/5 1/5 0/5

Left: 5/5 4/5 3/5 2/5 1/5 0/5

Wrist extension:

Right: 5/5 4/5 3/5 2/5 1/5 0/5

Left: 5/5 4/5 3/5 2/5 1/5 0/5

Grip:

Right: 5/5 4/5 3/5 2/5 1/5 0/5

Left: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
 Pinch (thumb to index finger):
 Right: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
 Left: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
 Hip extension:
 Right: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
 Left: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
 Hip flexion:
 Right: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
 Left: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5

 Knee extension:
 Right: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
 Left: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
 Ankle plantar flexion:
 Right: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
 Left: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
 Ankle dorsiflexion:
 Right: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
 Left: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5

If there are other weaknesses, please specify using the above format:

c. Deep tendon reflexes (DTRs)

Rate reflexes according to the following scale:

- 0 Absent
- 1+ Decreased
- 2+ Normal
- 3+ Increased without clonus
- 4+ Increased 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+

d. Sensation testing results:

___ All Normal

Shoulder area (C5): Right: ___ Normal ___ Decreased ___ Absent

Left: ___ Normal ___ Decreased ___ Absent

Inner/outer forearm (C6/T1):

Right: ___ Normal ___ Decreased ___ Absent

Left: ___ Normal ___ Decreased ___ Absent

Hand/fingers (C6-8): Right: ___ Normal ___ Decreased ___ Absent

Left: ___ Normal ___ Decreased ___ Absent

Thorax:

Anterior: Right: Normal Decreased Absent
 Left: Normal Decreased Absent
 Posterior: Right: Normal Decreased Absent
 Left: Normal Decreased Absent
 Trunk:
 Anterior: Right: Normal Decreased Absent
 Left: Normal Decreased Absent
 Posterior: Right: Normal Decreased Absent
 Left: Normal Decreased Absent
 Thigh/knee (L3/4): Right: Normal Decreased Absent
 Left: Normal Decreased Absent
 Lower leg/ankle (L4/L5/S1):
 Right: Normal Decreased Absent
 Left: Normal Decreased Absent
 Foot/toes (L5): Right: Normal Decreased Absent
 Left: Normal Decreased Absent

e. Does the Veteran have muscle atrophy attributable to MS?

Yes No

If muscle atrophy is present, indicate location: _____

When possible, provide difference measured in cm between normal and atrophied side, measured at maximum muscle bulk: _____ cm.

f. Summary of muscle weakness in the upper and/or lower extremities attributable to MS (check all that apply):

Right upper extremity muscle weakness:

None Mild Moderate Severe
 With atrophy Complete (no remaining function)

Left upper extremity muscle weakness:

None Mild Moderate Severe
 With atrophy Complete (no remaining function)

Right lower extremity muscle weakness:

None Mild Moderate Severe
 With atrophy Complete (no remaining function)

Left lower extremity muscle weakness:

None Mild Moderate Severe
 With atrophy Complete (no remaining function)

NOTE: If the Veteran has more than one medical condition contributing to the muscle weakness, identify the condition(s) and describe each condition's contribution to the muscle weakness: _____

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes No

If yes, also complete a Scars Questionnaire.

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

listed in the Diagnosis section above?

Yes No

If yes, describe (brief summary): _____

6. Mental health manifestations due to multiple sclerosis or its treatment

a. Does the Veteran have signs or symptoms of depression, cognitive impairment or dementia, or any other mental disorder attributable to MS and/or its treatment?

Yes No

If yes, briefly describe: _____

If yes, also complete a Mental Disorder DBQ (schedule with appropriate provider).

b. Does the Veteran's mental disorder, 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 signs and symptoms of the Veteran's mental disorder: _____

7. Housebound

a. Is the Veteran substantially confined to his or her dwelling and the immediate premises (or if institutionalized, to the ward or clinical areas)?

Yes No

If yes, describe how often per day or week and under what circumstances the Veteran is able to leave the home or immediate premises: _____

b. If yes, does the Veteran have more than one condition contributing to his or her being housebound?

Yes No

If yes, list conditions and describe how each condition contributes to causing the Veteran to be housebound:

Condition #1: _____

Describe how condition #1 contributes to causing the Veteran to be housebound: _____

Condition #2: _____

Describe how condition #2 contributes to causing the Veteran to be housebound: _____

Condition #3: _____

Describe how condition #3 contributes to causing the Veteran to be housebound: _____

c. If the Veteran has additional conditions contributing to causing the Veteran to be housebound, list using above format: _____

8. Aid & Attendance

a. Is the Veteran able to dress or undress without assistance?

Yes No

If no, is this limitation caused by the Veteran's MS?

Yes No

b. Does the Veteran have sufficient upper extremity coordination and strength to be able to feed him or herself without assistance?

Yes No

If no, is this limitation caused by the Veteran's MS?

Yes No

c. Is the Veteran able to prepare meals without assistance?

Yes No

If no, is this limitation caused by the Veteran's MS?

Yes No

d. Is the Veteran able to attend to the wants of nature (toileting) without assistance?

Yes No

If no, is this limitation caused by the Veteran's MS?

Yes No

e. Is the Veteran able to bathe him or herself without assistance?

Yes No

If no, is this limitation caused by the Veteran's MS?

Yes No

f. Is the Veteran able to keep him or herself ordinarily clean and presentable without assistance?

Yes No

If no, is this limitation caused by the Veteran's MS?

Yes No

g. Is the Veteran able to take prescription medications in a timely manner and with accurate dosage without assistance?

Yes No

If no, is this limitation caused by the Veteran's MS?

Yes No

h. Does the Veteran need frequent assistance for adjustment of any special prosthetic or orthopedic appliance(s)?

Yes No

If yes, describe: _____

NOTE: For VA purposes, "bedridden" will be that condition which actually requires that the claimant remain in bed. The fact that claimant has voluntarily taken to bed or that a physician has prescribed rest in bed for the greater or lesser part of the day to promote convalescence or cure will not suffice.

i. Is the Veteran bedridden?

Yes No

If yes, is it due to the Veteran's MS?

Yes No

j. Is the Veteran legally blind?

Yes No

If yes, is it due to the Veteran's MS?

Yes No
Provide best corrected vision, if known
Left Eye: _____ Right Eye: _____

k. Does the Veteran require care and/or assistance on a regular basis due to his or her physical and/or mental disabilities in order to protect him or herself from the hazards and/or dangers incident to his or her daily environment?

Yes No
If yes, describe: _____
If yes, is it due to the Veteran's MS?
 Yes No

l. List any condition(s), in addition to the Veteran's MS, that causes any of the above limitations: _____

9. Need for higher level (i.e., more skilled) A&A

a. Does the Veteran require a higher, more skilled level of A&A?
 Yes No
If yes, describe what type of care: _____
NOTE: For VA purposes, this skilled, higher level care includes (but is not limited to) health-care services such as physical therapy, administration of injections, placement of indwelling catheters, changing of sterile dressings, and/or like functions which require professional health-care training or the regular supervision of a trained health-care professional to perform. In the absence of this higher level of care provided in the home, the Veteran would require hospitalization, nursing home care, or other residential institutional care.

10. 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: _____

11. Remaining effective function of the extremities

Due to MS, 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): _____

12. Financial responsibility

In your judgment, is the Veteran able to manage his/her benefit payments in his/her own best interest, or able to direct someone else to do so?

Yes No

If no, please describe: _____

13. Diagnostic testing

NOTE: If the results of MRI, other imaging studies or other diagnostic tests are in the medical record and reflect the Veteran's current condition, repeat testing is not required. If pulmonary function testing (PFT) is indicated due to respiratory disability, and results are in the medical record and reflect the Veteran's current respiratory function, repeat testing is not required. DLCO and bronchodilator testing is not indicated for a restrictive respiratory disability such as that caused by muscle weakness due to MS.

a. Have imaging studies been performed?

Yes No

If yes, provide most recent results, if available: _____

b. Have PFTs been performed?

Yes No

If yes, provide most recent results, if available:

FEV-1: _____% predicted Date of test: _____

FEV-1/FVC: _____% predicted Date of test: _____

FEV: _____% predicted Date of test: _____

c. If PFTs have been performed, is the flow-volume loop compatible with upper airway obstruction?

Yes No

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): _____

14. Functional impact

Does the Veteran's MS impact his or her ability to work?

Yes No

If yes, describe impact of the Veteran's MS, providing one or more examples: _____

15. 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 Non-Degenerative Arthritis(Including inflammatory, autoimmune, crystalline and infectious arthritis) and Dysbaric Osteonecrosis

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 inflammatory, autoimmune, crystalline or infectious arthritis or dysbaric osteonecrosis (Caisson disease)?

Yes No

If yes, indicate the diagnosis:

- Gout ICD code(s): _____ Date of diagnosis: _____
- Rheumatoid arthritis (atrophic ICD code(s): _____ Date of diagnosis: _____
- Gonorrhoeal arthritis ICD code(s): _____ Date of diagnosis: _____
- Pneumococccic arthritis ICD code(s): _____ Date of diagnosis: _____
- Typhoid arthritis ICD code(s): _____ Date of diagnosis: _____
- Syphilitic arthritis ICD code(s): _____ Date of diagnosis: _____
- Streptococccic arthritis ICD code(s): _____ Date of diagnosis: _____
- Dysbaric osteonecrosis (Caisson Disease of Bone) ICD code(s): _____ Date of diagnosis: _____

Other

If checked, provide only diagnoses that pertain to inflammatory, autoimmune, crystalline or infectious arthritis.

Other diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____

Other diagnosis #2: _____
ICD code: _____
Date of diagnosis: _____

Other diagnosis #3: _____
ICD code: _____
Date of diagnosis: _____

If there are additional diagnoses that pertain to inflammatory, autoimmune, crystalline or infectious arthritis list using above format: _____

2. Medical history

a. Describe history (including onset and course) of the Veteran's inflammatory, autoimmune, crystalline or infectious arthritis or dysbaric osteonecrosis (brief summary):

b. Does the Veteran require continuous use of medication for this arthritis condition?

Yes No

If yes, list only those medications used for this arthritis: _____

c. Has the Veteran lost weight due to this arthritis condition?

Yes No

If yes, provide baseline weight (average weight for 2-year period preceding onset of disease): _____, and current weight: _____.

If yes, does the Veteran's weight loss attributable to this arthritis condition cause impairment of health?

Yes No

If yes, describe the impairment: _____

d. Does the Veteran have anemia due to this arthritis condition?

Yes No

If yes, does the Veteran's anemia attributable to this arthritis condition cause impairment of health?

Yes No

If yes, describe the impairment (also provide CBC under diagnostic testing section #9):

3. Joint involvement

a. Does the Veteran have pain (with or without joint movement) attributable to this arthritis condition?

Yes No

If yes, indicate affected joints (check all that apply):

Cervical spine Thoracolumbar spine Sacroiliac joints

Right: Shoulder Elbow Wrist Hand/fingers Hip Knee Ankle Foot/toes

Left: Shoulder Elbow Wrist Hand/fingers Hip Knee Ankle Foot/toes

For all checked joints, describe involvement (brief summary): _____

Also complete a Questionnaire for each affected joint, if indicated.

b. Does the Veteran have any limitation of joint movement attributable to this arthritis condition?

Yes No

If yes, indicate affected joints (check all that apply):

Cervical spine Thoracolumbar spine Sacroiliac joints

Right: Shoulder Elbow Wrist Hand/fingers Hip Knee Ankle Foot/toes

Left: Shoulder Elbow Wrist Hand/fingers Hip Knee Ankle Foot/toes

For all checked joints, describe limitation of movement (brief summary): _____

Also complete a Questionnaire for each affected joint, if indicated.

c. Does the Veteran have any joint deformities attributable to this arthritis condition?

Yes No

If yes, indicate affected joints (check all that apply):

Cervical spine Thoracolumbar spine Sacroiliac joints

Right: Shoulder Elbow Wrist Hand/fingers Hip Knee Ankle

Foot/toes

Left: Shoulder Elbow Wrist Hand/fingers Hip Knee Ankle Foot/toes

For all checked joints, describe deformities (brief summary): _____

Also complete a Questionnaire for each affected joint, if indicated.

4. Systemic involvement other than joints

Does the Veteran have any involvement of any systems, other than joints, attributable to this arthritis condition?

Yes No

If yes, indicate systems involved (check all that apply):

Ophthalmological Skin and mucous membranes Hematologic Pulmonary

Cardiac Neurologic Renal Gastrointestinal Vascular

For all checked systems, describe involvement (brief summary): _____

Also complete the appropriate Questionnaire if indicated.

5. Incapacitating and non-incapacitating exacerbations

a. Due to the arthritis condition, does the Veteran have exacerbations which are not incapacitating?

Yes No

If yes, indicate frequency of non-incapacitating exacerbations per year:

0 1 2 3 4 or more

Date of most recent non-incapacitating exacerbation: _____

Duration of most recent non-incapacitating exacerbation: _____

Describe non-incapacitating exacerbation: _____

b. Due to the arthritis condition, does the Veteran have exacerbations which are incapacitating?

Yes No

If yes, describe: _____

Indicate frequency of incapacitating exacerbations per year:

0 1 2 3 4 or more

Date of most recent incapacitating exacerbation: _____

Duration of most recent incapacitating exacerbation: _____

Describe incapacitating exacerbation: _____

c. Due to the arthritis condition, does the Veteran have constitutional manifestations associated with active joint involvement which are totally incapacitating?

Yes No

If yes, has the Veteran been totally incapacitated due to this during the past 12 months?

Yes No

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

< 1 week

1 week to < 2 weeks

2 weeks to < 4 weeks

4 weeks to < 6 weeks

6 weeks or more

Describe constitutional manifestations and the manner in which those manifestations cause incapacitation:

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

Yes No

If yes, describe (brief summary): _____

7. 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: _____

8. Remaining effective function of the extremities

Due to the Veteran's inflammatory, autoimmune, crystalline or infectious arthritis or dysbaric osteonecrosis, 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 extremities for which this applies:

Right upper Left upper Right lower Left lower

For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary): _____

9. Diagnostic testing

The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

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

Yes No

If yes, indicate type of study:

X-ray Area imaged: _____ Date: _____ Results: _____
 Other, specify: _____ Area imaged: _____ Date: _____ Results: _____

b. Have laboratory studies been performed?

NOTE: Once a diagnosis has been confirmed, laboratory studies are not indicated for a disability exam.

Yes No

If yes, check all that apply:

Erythrocyte sedimentation rate (ESR) Date of test: _____ Results: _____
 C-reactive protein Date of test: _____ Results: _____
 Rheumatoid factor (RF) Date of test: _____ Results: _____
 Anti-DNA antibodies Date of test: _____ Results: _____
 Antinuclear antibodies (ANA) Date of test: _____ Results: _____
 Anti-cyclic citrullinated peptide (anti-CCP) antibodies Date of test: _____ Results: _____
 CBC Date of test: _____
Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____
Platelets: _____
 Uric Acid Test Date of test: _____ Results: _____
 Other, specify: _____ Date of test: _____ Results: _____

c. Has the Veteran had a joint aspiration/synovial fluid analysis?

NOTE: Once a diagnosis has been confirmed, testing is not indicated for a disability exam.

Yes No

If yes, indicate joint aspirated, date and results: _____

d. Has the Veteran had a biopsy (e.g., skin, nerve, fat, rectum, kidney)?

NOTE: Once a diagnosis has been confirmed, testing is not indicated for a disability exam.

Yes No

If yes, indicate area biopsied, date and 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 inflammatory, autoimmune, crystalline or infectious arthritis condition or dysbaric osteonecrosis impact his or her ability to work?

Yes No

If yes describe the impact of each of the Veteran's arthritis or osteonecrosis 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.

6.14. DBQ Osteomyelitis

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 osteomyelitis?

Yes No

If yes, provide only diagnoses that pertain to osteomyelitis:

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 osteomyelitis, list using above format: _____

2. Medical History

a. Describe the history (including onset and course) of the Veteran's osteomyelitis (brief summary):

b. Indicate location of initial infection (check all that apply):

Pelvis

Cervical vertebrae

Thoracolumbar vertebrae

Long bones of upper extremity

Side affected: Right Left

Long bones of lower extremity

Side affected: Right Left

Finger(s): Right, digit(s) affected _____ Left, digit(s) affected _____

Toe(s): Right, digit(s) affected _____ Left, digit(s) affected _____

Other, specify: _____

Extension into joints

If checked, indicate joints affected:

Right: Shoulder Elbow Wrist Hip Knee Ankle

Multiple hand joints Multiple foot joints

Left: Shoulder Elbow Wrist Hip Knee Ankle

Multiple hand joints Multiple foot joints

Other, specify: _____

c. Has the Veteran had medical treatment or is the Veteran currently undergoing medical treatment for osteomyelitis?

Yes No

If yes, describe treatment: _____

Date treatment started: _____

Date treatment completed or anticipated date of completion: _____

d. Has the Veteran had surgical treatment for osteomyelitis?

Yes No

If yes, indicate surgical procedure and date (if multiple procedures, indicate below):

Procedure #1: _____

Date: _____

Facility: _____

Procedure #2: _____

Date: _____

Facility: _____

If additional surgical procedures, list, using above format: _____

e. Provide status of the Veteran's current osteomyelitis condition:

Acute Subacute Chronic Inactive Resolved Other: describe: _____

3. Recurrent infections

a. Has the Veteran had any additional episodes or recurring infections of osteomyelitis following the initial infection?

Yes No

If yes, indicate number of additional episodes:

1 2 3 4 5 or more

b. Location of recurrent infections (check all that apply):

Pelvis

Cervical vertebrae

Thoracolumbar vertebrae

Long bones of upper extremity

Side affected: Right Left

Long bones of lower extremity

Side affected: Right Left

Finger(s): Right, digit(s) affected _____

Left, digit(s) affected _____

Toe(s): Right, digit(s) affected _____

Left, digit(s) affected _____

Other, specify: _____

Extension into joints

If checked, indicate joints affected:

Right: Shoulder Elbow Wrist Hip Knee Ankle

Multiple hand joints Multiple foot joints

Left: Shoulder Elbow Wrist Hip Knee Ankle

Multiple hand joints Multiple foot joints

Other, specify: _____

c. Dates of recurrent infection

Indicate dates of recurrences:

Date of recurrence #1: _____ Site of recurrent infection: _____
Date of recurrence #2: _____ Site of recurrent infection: _____
Date of recurrence #3: _____ Site of recurrent infection: _____

If there are additional recurrences, list using above format: _____

4. Signs, symptoms and findings

a. Does the Veteran currently have any signs or findings attributable to osteomyelitis or treatment for osteomyelitis?

Yes No

If yes, check all that apply:

- Involucrum
- Sequestrum
- Discharging sinus
- Amyloidosis secondary to chronic infection
- Anemia

If checked, provide CBC results in diagnostic testing section.

Decreased joint function or range of motion due to osteomyelitis or residuals of treatment

If checked, indicate affected joints and ALSO complete appropriate Questionnaire for each affected joint and/or spinal segment.

Right: Shoulder Elbow Wrist Hip Knee Ankle

Multiple hand joints Multiple foot joints Single hand joint

Single foot joint

Left: Shoulder Elbow Wrist Hip Knee Ankle

Multiple hand joints Multiple foot joints Single hand joint

Single foot joint

Cervical vertebral joint(s) Thoracolumbar vertebral joint(s)

Specific vertebral joint(s) affected _____

b. Does the Veteran currently have any symptoms attributable to osteomyelitis or treatment for osteomyelitis?

Yes No

If yes, check all that apply:

Pain

If checked, describe: _____

Swelling

If checked, describe: _____

Tenderness

If checked, describe: _____

Erythema

If checked, describe: _____

Warmth

If checked, describe: _____

Malaise

If checked, describe: _____

Other symptoms, describe: _____

5. Amputation

Has the Veteran had an amputation due to osteomyelitis?

Yes No

If yes, complete Amputation Questionnaire.

6. Assistive devices

a. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible?

Yes No

If yes, identify assistive devices 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: _____

7. Remaining effective function of the extremities

Due to the Veteran's osteomyelitis or residuals of treatment, 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 extremities for which this applies:

- Right upper Left upper Right lower Left lower

For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary): _____

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

Yes No

If yes, describe (brief summary): _____

9. Diagnostic testing

a. Have imaging or laboratory studies performed and are the results available?

Yes No

If yes, indicate tests performed, dates and results:

- Bone scan Date of test: _____ Results: _____
- X-ray Date of test: _____ Results: _____
- MRI Date of test: _____ Results: _____
- Complete blood count (CBC) Date of test: _____ Results: _____
- C-reactive protein (CRP) Date of test: _____ Results: _____
- Erythrocyte sedimentation rate (ESR) Date of test: _____ Results: _____
- Blood culture Date of test: _____ Results: _____
- Bone biopsy and culture Date of test: _____ Results: _____

Other, describe: _____
Date of test: _____ 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): _____

10. Functional impact

Does the Veteran's osteomyelitis impact his or her ability to work? Yes No

If yes describe the impact of the Veteran's osteomyelitis or residuals of treatment, 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.

6.15. DBQ Peritoneal Adhesions

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 peritoneal adhesion?

Yes No

If yes, provide only diagnoses that pertain to peritoneal adhesions:

Diagnosis #1: _____

ICD code: _____

Date of diagnosis #1: _____

Diagnosis #2: _____

ICD code: _____

Date of diagnosis #2: _____

Diagnosis #3: _____

ICD code: _____

Date of diagnosis #3: _____

If there are additional diagnoses that pertain to peritoneal adhesions, list using above format: _____

2. Medical history

a. Describe the history (including cause, onset and course) of the Veteran's peritoneal adhesions (brief summary):

b. Does the Veteran have a history of operative, traumatic or infectious (intraabdominal) process?

Yes No

If yes, indicate organ(s) affected (check all that apply):

Stomach Gall bladder Liver Small intestine Large intestine other: _____

c. Has the Veteran had severe peritonitis, ruptured appendix, perforated ulcer or operation with drainage?

Yes No

d. Does the Veteran have a current diagnosis of peritoneal adhesions?

Yes No

If yes, indicate organ(s) affected (check all that apply):

Stomach Gall bladder Liver Small intestine Large intestine other: _____

e. Does the Veteran have any signs and/or symptoms due to peritoneal adhesions?

Yes No

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

- Delayed motility of barium meal (on X-ray)
- Partial or complete bowel obstruction
- Reflex disturbances
- Pain
- Nausea

- Vomiting
- Abdominal distention
- Constipation (perhaps alternating with diarrhea)

f. Does the Veteran's treatment plan include taking continuous medication for the diagnosed condition?
 Yes No List medications: _____

3. Severity of manifestations of peritoneal adhesions

Indicate level of severity of signs and/or symptoms, if present: (check all that apply in each level)

a. Level IV

- Severe
- Definite partial obstruction shown by x-ray
- Frequent episodes of severe colic distension
- Frequent episodes of severe nausea
- Frequent episodes of severe vomiting
- Prolonged episodes of severe colic distension
- Prolonged episodes of severe nausea
- Prolonged episodes of severe vomiting

b. Level III

- Moderately severe
- Partial obstruction manifested by delayed motility of barium meal
- Less frequent episodes of pain
- Less prolonged episodes of pain

c. Level II

- Moderate
- Pulling pain on attempting work or aggravated by movements of the body
- Occasional episodes of colic pain
- Occasional episodes of nausea
- Occasional episodes of constipation (perhaps alternating with diarrhea)
- Abdominal distention

d. Level I

- Mild, describe: _____

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

- Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

- Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

- Yes No

If yes, describe (brief summary): _____

5. Diagnostic testing

Has the Veteran had laboratory or other diagnostic studies performed and are the results available?

Yes No

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

6. Functional impact

Based on your examination and/or the Veteran's history, does the Veteran's peritoneal adhesion(s) impact his or her ability to work?

Yes No

If yes, describe the impact of each of the Veteran's peritoneal adhesions, 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 Rectum and Anus Conditions (including Hemorrhoids)

Name of patient/Veteran: _____ SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever had any condition of the rectum or anus?

Yes No

If yes, provide only diagnoses that pertain to rectum or anus conditions.

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

<input type="checkbox"/> Internal or external hemorrhoids	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Anal/perianal fistula	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Rectal stricture	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Impairment of rectal sphincter control	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Rectal prolapse	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Pruritus ani	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> 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 rectum or anus conditions, list using above format: _____

2. Medical History

a. Describe the history (including onset and course) of the Veteran's rectum or anus conditions (brief summary): _____

b. Does the Veteran's treatment plan include taking continuous medication for the diagnosed conditions?

Yes No

If yes, list only those medications used for the diagnosed conditions: _____

3. Signs and Symptoms

Does the Veteran have any findings, signs or symptoms attributable to any of the diagnoses in Section 1?

Yes No

If yes, specify the conditions below and complete the appropriate sections.

a. Internal or external hemorrhoids

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

Mild or moderate

If checked, describe: _____

Large or thrombotic, irreducible, with excessive redundant tissue, evidencing frequent recurrences

With persistent bleeding

With secondary anemia

If checked, provide hemoglobin/hematocrit in Diagnostic testing section.

With fissures

Other, describe: _____

b. Anal/perianal fistula

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

Slight impairment of sphincter control, without leakage

If checked, describe: _____

Leakage necessitates wearing of pad

Constant slight leakage

Occasional moderate leakage

Occasional involuntary bowel movements

Extensive leakage

Fairly frequent involuntary bowel movements

Complete loss of sphincter control

Other, describe: _____

c. Rectal stricture

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

Moderate reduction of lumen

Great reduction of lumen

Moderate constant leakage

Extensive leakage

Requiring colostomy (which is present)

Other, describe: _____

d. Impairment of rectal sphincter control

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

Slight impairment of sphincter control, without leakage

If checked, describe: _____

Leakage necessitates wearing of pad

Constant slight leakage

Occasional moderate leakage

Occasional involuntary bowel movements

Extensive leakage

Fairly frequent involuntary bowel movements

Complete loss of sphincter control

Other, describe: _____

e. Rectal prolapse

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

Mild with constant slight or occasional moderate leakage

Moderate, persistent or frequently recurring

Severe (or complete), persistent

Other, describe: _____

f. Pruritus ani

If checked, indicate underlying condition and describe: _____

If appropriate, complete Questionnaire for underlying condition, such as the Skin Questionnaire.

4. Exam

Provide results of examination of rectal/anal area: (check all that apply)

No exam performed for this condition; provide reason: _____

Normal; no external hemorrhoids, anal fissures or other abnormalities

No external hemorrhoids; skin tags only

Small or moderate external hemorrhoids

Large external hemorrhoids

Thrombotic external hemorrhoids

Reducible external hemorrhoids

- Irreducible external hemorrhoids
- Excessive redundant tissue
- Anal fissure(s)
If checked, describe: _____
- Other, describe: _____

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

- Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

- Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs 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 imaging studies, diagnostic procedures or laboratory testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report.

a. Has laboratory testing been performed?

- Yes No

If yes, check all that apply:

- CBC (if anemia due to any intestinal condition is suspected or present)

Date of test: _____

Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____

- Other, 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. 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 rectum or anus condition impact his or her ability to work?

- Yes No

If yes, describe the impact of each of the Veteran's rectum or anus conditions, 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.

6.17. DBQ Sleep Apena

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 sleep apnea?

Yes No

If yes, provide only diagnoses that pertain to sleep apnea and check diagnostic type:

Obstructive ICD code: _____ Date of diagnosis: _____
 Central ICD code: _____ Date of diagnosis: _____
 Mixed, components of both ICD code: _____ Date of diagnosis: _____
 Other sleep disorder, specify: _____
ICD code: _____ Date of diagnosis: _____

If there are additional diagnoses that pertain to a diagnosis of sleep apnea list using above format: _____

NOTE: The diagnosis of sleep apnea must be confirmed by a sleep study; provide sleep study results in Diagnostic testing section.

If other respiratory condition is diagnosed, complete the Respiratory and/or Narcolepsy Questionnaire(s), in lieu of this one.

2. Medical history

a. Describe the history (including onset and course) of the Veteran's sleep disorder condition (brief summary):

b. Is continuous medication required for control of a sleep disorder condition?

Yes No

If yes, list only those medications required for the Veteran's sleep disorder condition: _____

c. Does the Veteran require the use of a breathing assistance device such as continuous positive airway pressure (CPAP) machine?

Yes No

3. Findings, signs and symptoms

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

Yes No

If yes, check all that apply:

- Persistent daytime hypersomnolence
- Evidence of chronic respiratory failure with carbon dioxide retention
- Cor pulmonale
- Requires tracheostomy
- Other, describe: _____

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms 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 sleep apnea condition, repeat testing is not required.

a. Has a sleep study been performed?

Yes No

If yes, does the Veteran have documented sleep disorder breathing?

Yes No

Date of sleep study: _____

Facility where sleep study performed, if known: _____

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 sleep apnea impact his or her ability to work?

Yes No

If yes, describe impact of the Veteran's sleep apnea, 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.

6.18. DBQ Stomach and Duodenal Conditions (Not including GERD esophageal disorders)

Name of patient/Veteran: _____ SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

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

Yes No

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

- | | | |
|--|-----------------|--------------------------|
| <input type="checkbox"/> Gastric ulcer | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Duodenal ulcer | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Stenosis of the stomach | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Marginal (gastrojejunal) ulcer | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Hypertrophic gastritis | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Postgastrectomy syndrome | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Status post vagotomy with pyloroplasty | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Gastroenterostomy | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Peritoneal adhesions following injury or surgery of the stomach | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Helicobacter pylori | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Other stomach or duodenal conditions: | | |

Other diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____

Other diagnosis #2: _____
ICD code: _____
Date of diagnosis: _____

If there are additional diagnoses that pertain to stomach or duodenal conditions, list using above format: _____

NOTE: The diagnosis of gastric or duodenal ulcer or stenosis can be made by upper gastrointestinal imaging series or endoscopy. The diagnosis of gastritis requires endoscopic confirmation. If testing is of record and is consistent with Veteran's current condition, repeat testing is not required.

2. Medical History

a. Describe the history (including onset and course) of the Veteran's stomach or duodenum 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: _____

3. Signs and symptoms

Does the Veteran have any of the following signs or symptoms due to any stomach or duodenum conditions?

Yes No

If yes, check all that apply:

Recurring episodes of symptoms that are not severe

If checked, indicate frequency of episodes of symptom recurrence per year:

1 2 3 4 or more

If checked, indicate average duration of episodes of symptoms:

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

Recurring episodes of severe symptoms

If checked, indicate frequency of episodes of symptom recurrence per year:

1 2 3 4 or more

If checked, indicate average duration of episodes of symptoms:

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

Abdominal pain

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

Occurs less than monthly

Occurs at least monthly

Pronounced

Periodic

Continuous

Relieved by standard ulcer therapy

Only partially relieved by standard ulcer therapy

Unrelieved by standard ulcer therapy

Anemia

If checked, provide hemoglobin/hematocrit in diagnostic testing section.

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)

Nausea

If checked, indicate severity:

Mild Transient Recurrent Periodic

If checked, indicate frequency of episodes of nausea per year:

1 2 3 4 or more

If checked, indicate average duration of episodes of nausea:

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

Vomiting

If checked, indicate severity:

Mild Transient Recurrent Periodic

If checked, indicate frequency of episodes of vomiting per year:

1 2 3 4 or more

If checked, indicate average duration of episodes of vomiting:

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

Hematemesis

If checked, indicate severity:

Mild Transient Recurrent Periodic

If checked, indicate frequency of episodes of hematemesis per year:

1 2 3 4 or more

If checked, indicate average duration of episodes of hematemesis:

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

Melena

If checked, indicate severity:

Mild Transient Recurrent Periodic

If checked, indicate frequency of episodes of melena per year:

1 2 3 4 or more

If checked, indicate average duration of episodes of melena:

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

4. Incapacitating episodes

Does the Veteran have incapacitating episodes due to signs or symptoms of any stomach or duodenum condition?

Yes No

If yes, describe incapacitating episodes: _____

Indicate frequency of incapacitating episodes per year:

1 2 3 4 or more

Indicate average duration of incapacitating episodes:

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

5. Other conditions

Does the Veteran have any of the following conditions?

Yes No

If yes, indicate conditions and complete appropriate sections (check all that apply)

a. Hypertrophic gastritis

If checked, indicate severity:

No symptoms or findings

Chronic, with small nodular lesions, and symptoms

Chronic, with multiple small eroded or ulcerated areas, and symptoms

Chronic, with severe hemorrhages, or large ulcerated or eroded areas

Note: If atrophic gastritis is present, state the underlying cause: _____

b. Postgastrectomy syndrome

If checked, indicate severity:

No symptoms or findings

Mild; infrequent episodes of epigastric distress with characteristic mild circulatory symptoms or continuous mild manifestations

Moderate; less frequent episodes of epigastric disorders with characteristic mild circulatory symptoms after meals but with diarrhea and weight loss

Severe; associated with nausea, sweating, circulatory disturbance after meals, diarrhea, hypoglycemic symptoms and weight loss with malnutrition and anemia

c. Vagotomy with pyloroplasty or gastroenterostomy

If checked, indicate the severity of residuals following vagotomy with pyloroplasty or gastroenterostomy:

No symptoms or findings

Recurrent ulcer with incomplete vagotomy

Symptoms and confirmed diagnosis of alkaline gastritis, or of confirmed persisting diarrhea

Demonstrably confirmative postoperative complications of stricture or continuing gastric retention

d. Peritoneal adhesions following an injury or surgical procedure of the stomach or duodenum

If checked, ALSO complete the Peritoneal Adhesions Questionnaire.

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

Yes No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?

Yes No

If yes, describe (brief summary): _____

7. Diagnostic testing

NOTE: If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report. The diagnosis of gastric or duodenal ulcer or stenosis can be made by upper gastrointestinal imaging series or endoscopy.

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

Yes No

If yes, check all that apply:

Upper endoscopy

Date: _____ Results: _____

Upper GI radiographic studies

Date: _____ Results: _____

MRI

Date: _____ Results: _____

CT

Date: _____ Results: _____

Biopsy, specify site: _____

Date: _____ Results: _____

Other, specify: _____

Date: _____ Results: _____

b. Has laboratory testing been performed?

Yes No

If yes, check all that apply:

CBC

Hemoglobin: _____ Date of test: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____

Helicobacter pylori

Date of test: _____ Results: _____

Other, specify: _____

Date of test: _____ 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): _____

8. Functional impact

Do any of the Veteran's stomach or duodenum conditions impact his or her ability to work?

Yes No

If yes, describe impact of each of the Veteran's stomach or duodenum conditions, 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.

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*174.

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:

download.vista.med.va.gov

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	ftp.fo-albany.med.va.gov	[anonymous.software]
Hines	ftp.fo-hines.med.va.gov	[anonymous.software]
Salt Lake City	ftp.fo-slc.med.va.gov	[anonymous.software]

File Name	Format	Description
DVBA_27_P174_RN.PDF	Binary	Release Notes

7.3 Related Documents

The VistA Documentation Library (VDL) web site will also contain the DVBA*2.7*174 Release Notes. 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>