Compensation and Pension Record Interchange (CAPRI)

CAPRI Compensation and Pension Worksheet Module (CPWM) Templates and AMIE Worksheet Disability Benefits Questionnaires (DBQs)

Release Notes
Patch: DVBA*2.7*169

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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*169. (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs).

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

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1. Purpose

The purpose of this document is to provide an overview of the enhancements specifically designed for Patch DVBA*2.7*169.

2. Overview

This patch introduces enhancements to the AUTOMATED MED INFO EXCHANGE (AMIE) V 2.7 package and the Compensation & Pension Record Interchange (CAPRI) application, Compensation & Pension Worksheet Module (CPWM) in support of modified Compensation and Pension (C&P) Disability Benefit Questionnaires (DBQs).

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

This patch consists of template defects fixes. A word wrapping issue was identified in the reporting of the following DBQs. There are no changes to the content required.

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

In addition to this patch VBAVACO has approved the renaming of CAPRI DBQ LEUKEMIA to DBQ HAIRY CELL AND OTHER B-CELL LEUKEMIAS to avoid confusion with DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA questionnaire.

3. Associated Remedy Tickets & New Service Requests

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

4. Defects Fixes

There are defect fixes associated with patch DVBA*2.7*169. A word wrapping issue was reported with CAPRI DBQ Templates reports and has been corrected in this patch.

5. Enhancements

This section provides an overview of the modifications and primary functionality that will be delivered in Patch DVBA*2.7*169.

5.1. CAPRI DBQ Template Modifications

Veterans Benefits Administration Veterans Affairs Central Office (VBAVACO) has approved modifications for the following Disability Benefits Questionnaires:

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

VBAVACO has approved renaming the current "DBQ LEUKEMIA" CAPRI template to "DBQ HAIRY CELL AND OTHER B-CELL LEUKEMIAS", to avoid potential confusion with the "DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS, INCLUDING LEUKEMIA" template

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

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

5.1.2.1. Section 1: HEARING LOSS, 1 Objective Findings, the Instructions, the second sentence was changed to the following:

Old version:
"Report the decibel value, which ranges from - 10 dB to 105 dB, for each of the frequencies."

New version:
"Report the decibel (dB) value, which ranges from - 10 dB to 105 dB, for each of the frequencies."

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

Old version:
c. Validity of puretone test results:
☐ Test results are valid.
☐ Test results are invalid (not indicative of organic hearing loss).

New version:

c. Validity of puretone test results:

☐ Test results are valid for rating purposes.

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

5.1.2.3. Section 1: HEARING LOSS, 1 Objective Findings, part f, (Audiologic Findings)
A new selection both Right and Left Ear was added: "Unable to interpret reflexes due to artifact."

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

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

Old version:

a. Tinnitus associated with hearing loss

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

☐ The Veteran's tinnitus is not likely a symptom associated with Veteran's hearing loss, as Veteran does not have hearing loss according to VA criteria

b. Tinnitus not associated with hearing loss

NOTE: Select answer below and provide rationale.

The Veteran's tinnitus is:

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

☐ At least as likely as not (50% probability or greater) due to a known etiology (such as traumatic brain injury)
Etiology and rationale: _____

☐ Not caused by or a result of military noise exposure
Rationale: _____

☐ Cannot provide a medical opinion regarding the etiology of the Veteran's tinnitus without resorting to speculation
Reason speculation required: _____

New version:

Select answer below and provide rationale where requested:

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

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

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

☐ At least as likely as not (50% probability or greater) due to a known etiology (such as traumatic brain injury)
Etiology and rationale: _____

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

☐ Cannot provide a medical opinion regarding the etiology of the Veteran's tinnitus without resorting to speculation
Reason speculation required: _____

5.1.3. HEMIC (Changed from released version ~166)

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

Old version:

"If the Veteran has thrombocytopenia, select the answer that best represents the Veteran's condition:"

New version:

"If yes, check all that apply:"

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

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

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

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

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

☐ Cholesterol emboli	ICD code: _____	Date of diagnosis: _____
☐ Cystic kidney disease	ICD code: _____	Date of diagnosis: _____
☐ Congenital kidney disorder	ICD code: _____	Date of diagnosis: _____
☐ Other inherited kidney disorder, specify:	ICD code: _____	Date of diagnosis:_____

5.1.4.4 Section 2 (Medical history) was changed from:

Describe the history (including cause, onset and course) of the Veteran's kidney condition: _____

Old version:

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

_____

New version:

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

☐ Yes ☐ No

List medications taken for the diagnosed condition: _____

5.1.4.5. Section 3 (Renal dysfunction), the top question is no longer designated part a and the subsequent parts have been re-lettered. In addition the question was changed:

Old version:

Does the Veteran have renal dysfunction?

☐ Yes ☐ No

New version:

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

☐ Yes ☐ No

If yes, complete the following section:

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

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

Old version:

c. Does the Veteran have kidney, ureteral or bladder calculi?
☐ Yes ☐ No
If yes, indicate location (check all that apply)
☐ Kidney ☐ Ureter ☐ Bladder
If the Veteran has urolithiasis, complete the following:

New version:

Does the Veteran now have or has he/she ever had kidney, ureteral or bladder calculi (urolithiasis)?
☐ Yes ☐ No
If yes, complete the following section:

a. Indicate current/past location of calculi (check all that apply)
☐ Kidney ☐ Ureter ☐ Bladder

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

Old version:

Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?
☐ Yes ☐ No
If yes, provide etiology: _____

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

New version:

Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?
☐ Yes ☐ No
If yes, complete the following section:

c. Etiology of recurrent urinary tract or kidney infections: _____

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

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

Old version:

a. Has the Veteran had a kidney removed?

☐ Yes ☐ No
If yes, provide reason:
☐ Kidney donation
☐ Due to disease
☐ Due to trauma or injury
☐ Other, describe: _____

New version:

Has the Veteran had a kidney transplant or removal?
☐ Yes ☐ No
If yes, complete the following section:
a. Has the Veteran had a kidney removed?

☐ Yes ☐ No
If yes, provide reason:
☐ Kidney donation
☐ Due to disease
☐ Due to trauma or injury

☐ Other, describe: _____

5.1.4.10. Section 6 part b question has been changed to the following:
Old version If Yes statement:
"If yes, date of admission:"

New version If yes statement:
"If yes, date of transplant:"

Old version Date questions statement:
"Date of discharge:"

New version questions statement:
"Name of treatment facility, date of admission and date of discharge for transplant:"

5.1.4.11. Section 7 (Tumors and neoplasms), part a, the sentence:"If yes, complete the following:" has been changed:
"If yes, complete the following section:"

5.1.4.12. Section 9 (Diagnostic testing), an additional sentence has been added to the NOTE:
"Provide testing completed appropriate to Veteran's condition; testing indicated below is not indicated for every kidney condition"

5.1.4.13.Section 9, part c, the selection:"Protein (albumin):"has been changed to following:
"Proteinuria (albumin):"

5.1.4.14.Section 9, part d, was changed to following:
Old version:
d. Urine microalbumin: Date: _____ Result: _____

New version:
d. Spot urine microalbumin/creatinine: Date: _____ Result: _____

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

5.1.5.1. Section 1 (Diagnosis), the following question has been removed:
"If no, provide rationale (e.g., Veteran has never had any known male reproductive organ conditions):"

5.1.5.2.Section 1 (Diagnosis), made the "c" in code lower case in all instances of "ICD code" and the "d" in diagnosis lower case in all instances of "Date of diagnosis"

5.1.5.3. Section 2 (Medical History), part b, changed the following sentence:
Old version:
"List medications:"

New version:
"List medications taken for the diagnosed condition:"

5.1.5.4. A new question was added to section 3 (Voiding dysfunction):
"a. Etiology of voiding dysfunction:"

5.1.5.5.Section 4 (Urinary tract/kidney infection), the following question has been changed:
Old version:
"If yes, provide etiology:"

New version:
"If yes, complete the following section:"

5.1.5.6.Section 4, consist of a new question that was added:
"a. Etiology of recurrent urinary tract or kidney infections:"

5.1.5.7.Section 5 (Erectile dysfunction), the following question "If yes, provide etiology:" has been changed to the following:
"If yes, complete the following section:"

5.1.5.8.Section 5 the following new question was added:
"a. Etiology of erectile dysfunction:"

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

5.1.5.19.Section 6, the following new question was added:
"a. Etiology of retrograde ejaculation:"

5.1.5.11. Section 7 (Male reproductive organ infections), the following sentence has been changed;
Old version:
"If yes, indicate all treatment modalities that apply:"

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

5.1.5.12.Section 8 (Physical exam), part a, the following selection has been changed:
Old version:
"Not examined; penis exam not relevant to condition"

New version:
"Not examined per Veteran's request; Veteran reports normal anatomy with no penile deformity or abnormality"

5.1.5.13.Section 8 (Physical exam), part b, the following selection has been changed:
Old version:
Not examined; testicular exam not relevant to condition"

New version:
"Not examined per Veteran's request; Veteran reports normal anatomy with no testicular deformity or abnormality"

5.1.5.14. Section 8 (Physical exam), part c, the following selection has been changed:
Old version:
"Not examined; epididymis exam not relevant to condition"

New version:
"Not examined per Veteran's request; Veteran reports normal anatomy of epididymis with no deformity or abnormality"

5.1.5.15.Section 9 (Tumors and neoplasms), the top question is no longer designated as part a, and the remaining subsections have been re-lettered.

5.1.5.16.Section 9, under the top question, the following sentence has been changed:
Old version:
"If yes, complete the following:"

New version:
"If yes, complete the following section:"

5.1.5.17.Section 11 (Diagnostic testing),the following sentence has been added to the NOTE:
"When appropriate, provide most recent results. No specific studies are required for this examination."

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

a. Has the Veteran had a testicular biopsy to determine the presence of spermatozoa?
☐ Yes ☐ No
If yes, were spermatozoa present?
☐ Yes ☐ No
Date of biopsy: _____

New version

a. Has a testicular biopsy been performed?
☐ Yes ☐ No
Date of biopsy: _____
Results:
☐ Spermatozoa present
☐ Other, describe: _____

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

5.1.6.1.Section 1 (Diagnosis), the following question has been removed:
"If no, provide rationale (e.g. Veteran has never had prostate cancer):"

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

5.1.7.1.Section 2 (Medical History), part c, the following sentence has been removed:
"If yes, also complete the Tumors and Neoplasms Questionnaire."

5.2. AMIE DBQ Worksheet Modifications

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

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

VBAVACO has approved renaming the current "DBQ LEUKEMIA" AMIE worksheet to "DBQ HAIRY CELL AND OTHER B-CELL LEUKEMIAS", to avoid potential confusion with the "DBQ HEMIC AND LYMPHATIC CONDITIONS INCLUDING LEUKEMIA" worksheet.

5.3. CAPRI Template Defects

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

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

On the **DBQ AMYOTROPHIC LATERAL SCLEROSIS (LOU GEHRIG'S DISEASE)** template, a defect in section 4.g. has been repaired. The prompt reads "check all that apply", but only one option can be selected. This has been fixed to allow selection of multiple options.

5.4. AMIE Worksheets Defects

There are no AMIE Worksheet defects associated with this patch.

6. Disability Benefits Questionnaires (DBQs)

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

6.1. DBQ Hearing Loss and Tinnitus

1. Objective Findings

a. Puretone thresholds in decibels (air conduction):

Instructions: Measure and record puretone threshold values in decibels at the indicated frequencies (air conduction). Report the decibel value, which ranges from - 10 dB to 105 dB, for each of the frequencies. Add a plus behind the decibel value when a maximum value has been reached with a failure of response from the Veteran. In those circumstances where the average includes a failure of response at either the maximum allowable limit (105 dB) or the maximum limits of the audiometer, use this maximum decibel value of the failure of response in the puretone threshold average calculation.

If the Veteran could not be tested (CNT), enter CNT and state the reason why the Veteran could not be tested. Clearly inaccurate, invalid or unreliable test results should not be reported.

The puretone threshold at 500 Hz is not used in calculating the puretone threshold average for evaluation purposes but is used in determining whether or not for VA purposes, hearing impairment reaches the level of a disability. The puretone threshold average requires the decibel levels of each of the required frequencies (1000 Hz, 2000 Hz, 3000 Hz, and 4000 Hz) be recorded for the test to be valid for determination of a hearing impairment.

RIGHT EAR

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

LEFT EAR

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

*The puretone threshold at 500 Hz is not used in determining the evaluation but is used in determining whether or not a ratable hearing loss exists.
**The average of B, C, D, and E.
***CNT – Could Not Test

b. Were there one or more frequency(ies) that could not be tested?
☐ Yes ☐ No

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

c. Validity of puretone test results:

☐ Test results are valid.

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

If invalid, provide reason: _____

d. Speech Discrimination Score (Maryland CNC word list)

Instructions on pausing: Examiners should pause when necessary during speech discrimination tests, in order to give the Veteran sufficient time to respond. This will ensure that the test results are based on actual hearing loss rather than on the effects of other problems that might slow a Veteran's response. There are a variety of problems that might require pausing, for example, the presence of cognitive impairment. It is up to the examiner to determine when to use pausing and the length of the pauses.

RIGHT EAR	%
LEFT EAR	%

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

☐ Use of speech discrimination score is appropriate for this Veteran.

☐ The use of the speech discrimination score is not appropriate for this Veteran because of language difficulties, cognitive problems, inconsistent speech discrimination scores, etc., that make combined use of puretone average and speech discrimination scores inappropriate.

f. Audiologic Findings

Summary of Immittance (Tympanometry) Findings:

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

2. Diagnosis

RIGHT EAR

☐ Normal hearing

☐ Conductive hearing loss ICD code: _____

☐ Mixed hearing loss ICD code: _____

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

☐ Sensorineural hearing loss (in the frequency range of 6000 Hz or higher frequencies) ** ICD code: _____

☐ Significant changes in hearing thresholds in service***

LEFT EAR

☐ Normal hearing

☐ Conductive hearing loss ICD code: _____

☐ Mixed hearing loss ICD code: _____

☐ Sensorineural hearing loss (in the frequency range of 500-4000 Hz)* ICD code: _____
☐ Sensorineural hearing loss (in the frequency range of 6000 Hz or higher frequencies) **
ICD code: _____
☐ Significant changes in hearing thresholds in service***

NOTES:
*The Veteran may have hearing loss at a level that is not considered to be a disability for VA purposes. This can occur when the auditory thresholds are greater than 25 dB at one or more frequencies in the 500-4000 Hz range.

** The Veteran may have impaired hearing, but it does not meet the criteria to be considered a disability for VA purposes. For VA purposes, the diagnosis of hearing impairment is based upon testing at frequency ranges of 500, 1000, 2000, 3000, and 4000 Hz. If there is no HL in the 500-4000 Hz range, but there is HL above 4000 Hz, check this box.

***The Veteran may have a significant change in hearing threshold in service, but it does not meet the criteria to be considered a disability for VA purposes. (A significant change in hearing threshold may indicate noise exposure or acoustic trauma.)

3. Evidence review
In order to provide an accurate medical opinion, the Veteran's records should be reviewed, if available.

Was the Veteran's VA claims file reviewed?
☐ Yes ☐ No

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

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

☐ Military service treatment records
☐ Military service personnel records
☐ Military enlistment examination
☐ Military separation examination
☐ Military post-deployment questionnaire
☐ Department of Defense Form 214 Separation Documents
☐ Veterans Health Administration medical records (VA treatment records)
☐ Civilian medical records
☐ Interviews with collateral witnesses (family and others who have known the Veteran before and after military service)
☐ Prior audiology reports
☐ Other: _____
☐ No records were reviewed

4. Etiology
If present, is the Veteran's hearing loss at least as likely as not (50% probability or greater) caused by or a result of an event in military service?
☐ Yes
☐ No
Rationale (Provide rationale for either a yes or no answer): _____
☐ Cannot provide a medical opinion regarding the etiology of the Veteran's hearing loss without resorting to speculation
Provide rationale for reason speculation required: _____
Did hearing loss exist prior to the service?
☐ Yes

☐ No
If yes, was the pre-existing hearing loss aggravated beyond normal progression in military service?
Right ear ☐ Yes ☐ No
Left ear ☐ Yes ☐ No
Provide rationale for both yes or no: _____

5. Functional impact of hearing loss
NOTE: Ask the Veteran to describe in his or her own words the effects of disability (i.e. the current complaint of hearing loss on occupational functioning and daily activities). Document the Veteran's response without opining on the relationship between the functional effects and the level of impairment (audiogram) or otherwise characterizing the response. Do not use handicap scales.
Does the Veteran's hearing loss impact ordinary conditions of daily life, including ability to work?
☐ Yes ☐ No
If yes, describe impact in the Veteran's own words: _____

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

SECTION 2: TINNITUS

1. Medical history
Does the Veteran report recurrent tinnitus?
☐ Yes ☐ No

Date and circumstances of onset of tinnitus: _____

2. Evidence review
In order to provide an accurate medical opinion, the Veteran's records should be reviewed, if available.

Was the Veteran's VA claims file reviewed?
☐ Yes ☐ No

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

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

☐ Military service treatment records
☐ Military service personnel records
☐ Military enlistment examination
☐ Military separation examination
☐ Military post-deployment questionnaire
☐ Department of Defense Form 214 Separation Documents
☐ Veterans Health Administration medical records (VA treatment records)
☐ Civilian medical records
☐ Interviews with collateral witnesses (family and others who have known the Veteran before and after military service)
☐ Prior audiology reports
☐ Other: _____
☐ No records were reviewed

3. Etiology of tinnitus

Select answer below and provide rationale where requested:
☐ The Veteran has a diagnosis of clinical hearing loss, and his or her tinnitus is at least as likely as not (50% probability or greater) a symptom associated with the hearing loss, as tinnitus is known to be a symptom associated with hearing loss
☐ Less likely than not (less than 50% probability) a symptom associated with the Veterans hearing loss
Rationale: _____
☐ At least as likely as not (50% probability or greater) caused by or a result of military noise exposure
Rationale: _____
☐ At least as likely as not (50% probability or greater) due to a known etiology (such as traumatic brain injury)
Etiology and rationale: _____
☐ Less likely than not (less than 50% probability) caused by or a result of military noise exposure
Rationale: _____
☐ Cannot provide a medical opinion regarding the etiology of the Veteran's tinnitus without resorting to speculation
Reason speculation required: _____

4. Functional impact of tinnitus

NOTE: Ask the Veteran to describe in his or her own words the effects of disability (i.e. the current complaint of tinnitus on occupational functioning and daily activities). Document the Veteran's response without opining on the relationship between the functional effects and the level of impairment (audiogram) or otherwise characterizing the response. Do not use handicap scales.

Does the Veteran's tinnitus impact ordinary conditions of daily life, including ability to work?
☐ Yes ☐ No
If yes, describe impact in the Veteran's own words: _____

5. Remarks, if any, pertaining to tinnitus: _____

Audiologist/clinician signature: _____ Date: _____

Audiologist/clinician printed name: _____

State audiology/examiner license #: _____ Physician address: _____
Phone: _____Fax: _____

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

6.2. DBQ Hematologic and Lymphatic Conditions, Including Leukemia

Name of patient/Veteran: _____SSN: _____

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

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with a hematologic or lymphatic condition?
☐ Yes ☐ No

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

☐ Acute lymphocytic leukemia (ALL) ICD code: _____ Date of diagnosis: _____
☐ Acute myelogenous leukemia (AML) ICD code: _____ Date of diagnosis: _____
☐ Chronic myelogenous leukemia (CML) ICD code: _____ Date of diagnosis: _____
☐ Chronic lymphocytic leukemia (CLL) ICD code: _____ Date of diagnosis: _____
☐ Hodgkin's disease ICD code: _____ Date of diagnosis: _____
☐ Non-Hodgkin's lymphoma ICD code: _____ Date of diagnosis: _____
☐ Multiple myeloma ICD code: _____ Date of diagnosis: _____
☐ Myelodysplastic syndrome ICD code: _____ Date of diagnosis: _____
☐ Plasmacytoma ICD code: _____ Date of diagnosis: _____
☐ Anemia (such as anemia of chronic disease, aplastic anemia, hemolytic anemia, iron or vitamin-deficient anemias, thalassemias, myelophthisic anemia, etc.)
ICD code: _____ Date of diagnosis: _____
☐ Thrombocytopenia ICD code: _____ Date of diagnosis: _____
☐ Polycythemia vera ICD code: _____ Date of diagnosis: _____
☐ Sickle cell anemia ICD code: _____ Date of diagnosis: _____
☐ Splenectomy ICD code: _____ Date of diagnosis: _____
☐ Hairy cell or other B-cell leukemia: If checked, complete Hairy cell and other B-cell leukemias Questionnaire in lieu of this Questionnaire.
☐ Other, specify:

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

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

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

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

2. Medical history

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

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

☐ Yes ☐ No

If yes, list only those medications required for control of the Veteran's hematologic or lymphatic condition, including anemia or thrombocytopenia caused by treatment for a hematologic or lymphatic condition. Provide the name of the medication and the condition the medication is used to treat: _____

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

- ☐ Active
- ☐ Remission
- ☐ Not applicable

3. Treatment

a. Has the Veteran completed any treatment or is the Veteran currently undergoing any treatment for any hematologic or lymphatic condition, including leukemia?

☐ Yes ☐ No; watchful waiting

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

- ☐ Treatment completed; currently in watchful waiting status
- ☐ Bone marrow transplant
  - If checked, provide:
  - Date of hospital admission and location: _____
  - Date of hospital discharge after transplant: _____
- ☐ Surgery
  - If checked, describe: _____
  - Date(s) of surgery: _____
- ☐ Radiation therapy
  - Date of most recent treatment: _____
  - Date of completion of treatment or anticipated date of completion: _____
- ☐ Antineoplastic chemotherapy
  - Date of most recent treatment: _____
  - Date of completion of treatment or anticipated date of completion: _____
- ☐ Other therapeutic procedure
  - If checked, describe procedure: _____
  - Date of most recent procedure: _____
- ☐ Other therapeutic treatment
  - If checked, describe treatment: _____
  - Date of completion of treatment or anticipated date of completion: _____

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

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

☐ Yes ☐ No

If yes, complete the following:

a. Does the Veteran have anemia?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

_____

b. Does the Veteran have thrombocytopenia?
☐ Yes ☐ No
If yes, is the thrombocytopenia caused by treatment for another hematologic or lymphatic condition?
☐ Yes ☐ No
If yes, provide the name of the other hematologic or lymphatic condition causing the secondary thrombocytopenia: _____

If yes, check all that apply:
- ☐ Stable platelet count of 100,000 or more
- ☐ Stable platelet count between 70,000 and 100,000
- ☐ Platelet count between 20,000 and 70,000
- ☐ Platelet count of less than 20,000
- ☐ With active bleeding
- ☐ Other, describe: _____

c. Does the Veteran have any complications or residuals of treatment requiring transfusion of platelets or red blood cells?
☐ Yes ☐ No
If yes, indicate frequency of transfusions in the past 12 months:
- ☐ None
- ☐ At least once per year but less than once every 3 months
- ☐ At least once every 3 months
- ☐ At least once every 6 weeks

5. Findings, signs and symptoms
Does the Veteran currently have any findings, signs and symptoms due to a hematologic or lymphatic disorder or to treatment for a hematologic or lymphatic disorder?
☐ Yes ☐ No
If yes, check all that apply:
- ☐ Weakness
  If checked, describe: _____
- ☐ Easy fatigability
  If checked, describe: _____
- ☐ Light-headedness
  If checked, describe: _____
- ☐ Shortness of breath
  If checked, describe: _____
- ☐ Headaches
  If checked, describe: _____
- ☐ Dyspnea on mild exertion
  If checked, describe: _____
- ☐ Dyspnea at rest
  If checked, describe: _____
- ☐ Tachycardia
  If checked, describe: _____
- ☐ Syncope
  If checked, describe: _____
- ☐ Cardiomegaly
- ☐ High output congestive heart failure
- ☐ Other, describe: _____

6. Recurring infections
Does the Veteran currently have recurring infections attributable to any conditions, complications or residuals of treatment for a hematologic or lymphatic disorder?
☐ Yes ☐ No
If yes, indicate frequency of infections over past 12 months:

☐ None
☐ At least once per year but less than once every 3 months
☐ At least once every 3 months
☐ At least once every 6 weeks

7. Polycythemia vera

Does the Veteran have polycythemia vera?
☐ Yes ☐ No
If yes, check all that apply:
☐ Stable, with or without continuous medication
☐ Requiring phlebotomy
☐ Requiring myelosuppressant treatment
☐ Other, describe: _____

NOTE: If there are complications due to polycythemia vera such as hypertension, gout, stroke or thrombotic disease, ALSO complete appropriate Questionnaire for each condition.

8. Sickle cell anemia

Does the Veteran have sickle cell anemia?
☐ Yes ☐ No
If yes, check all that apply:
☐ Asymptomatic
☐ In remission
☐ With identifiable organ impairment
☐ Following repeated hemolytic sickling crises with continuing impairment of health
☐ Painful crises several times a year
☐ Repeated painful crises, occurring in skin, joints, bones or any major organs
☐ With anemia, thrombosis and infarction
☐ Symptoms preclude other than light manual labor
☐ Symptoms preclude even light manual labor
☐ Other, describe: _____

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
☐ Yes ☐ No
If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms?
☐ Yes ☐ No
If yes, describe (brief summary): _____

10. Diagnostic testing

If testing has been performed and reflects Veteran's current condition, no further testing is required. When appropriate, provide most recent complete blood count.

a. Has laboratory testing been performed?

☐ Yes ☐ No

If yes, provide results:

Hemoglobin (gm/100ml): _____	Date: _____
Hematocrit: _____	Date: _____
Red blood cell (RBC) count: _____	Date: _____
White blood cell (WBC) count: _____	Date: _____
White blood cell differential count: _____	Date: _____
Platelet count: _____	Date: _____

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

☐ Yes ☐ No

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

11. Functional impact

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

☐ Yes ☐ No

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

12. Remarks, if any: _____

Physician signature: _____ Date: ___

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

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

6.3. DBQ Kidney Conditions (Nephrology)

Name of patient/Veteran: _____SSN: _____

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

1. Diagnosis:

Does the Veteran now have or has he/she ever been diagnosed with a kidney condition?
☐ Yes ☐ No

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

☐ Diabetic nephropathy	ICD code: _____	Date of diagnosis: _____
☐ Glomerulonephritis	ICD code: _____	Date of diagnosis: _____
☐ Hydronephrosis	ICD code: _____	Date of diagnosis: _____
☐ Interstitial nephritis	ICD code: _____	Date of diagnosis: _____
☐ Kidney transplant	ICD code: _____	Date of diagnosis: _____
☐ Nephrosclerosis	ICD code: _____	Date of diagnosis: _____
☐ Nephrolithiasis	ICD code: _____	Date of diagnosis: _____
☐ Renal artery stenosis	ICD code: _____	Date of diagnosis: _____
☐ Ureterolithiasis	ICD code: _____	Date of diagnosis: _____
☐ Neoplasm of the kidney	ICD code: _____	Date of diagnosis: _____
☐ Cholesterol emboli	ICD code: _____	Date of diagnosis: _____
☐ Cystic kidney disease	ICD code: _____	Date of diagnosis: _____
☐ Congenital kidney disorder	ICD code: _____	Date of diagnosis: _____
☐ Other inherited kidney disorder, specify:	ICD code: _____	Date of diagnosis: _____

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

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

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

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

2. Medical history

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

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

3. Renal dysfunction

Does the Veteran have renal dysfunction? (Evidence of renal dysfunction includes either persistent proteinuria, hematuria or GFR < 60 cc/min/1.73m2)
☐ Yes ☐ No
If yes, complete the following section:

a. Does the Veteran require regular dialysis?
☐ Yes ☐ No

b. Does the Veteran have any signs or symptoms due to renal dysfunction?
☐ Yes ☐ No
If yes, check all that apply:
☐ Proteinuria (albuminuria)
If checked, indicate frequency: (check all that apply)
☐ Recurring ☐ Constant ☐ Persistent
☐ Edema (due to renal dysfunction)
If checked, indicate frequency: (check all that apply)
☐ Some ☐ Transient ☐ Slight ☐ Persistent
☐ Anorexia (due to renal dysfunction)
☐ Weight loss (due to renal dysfunction)
If checked, provide baseline weight (average weight for 2-year period preceding onset of disease):
_____
Provide current weight: _____
☐ Generalized poor health due to renal dysfunction
☐ Lethargy due to renal dysfunction
☐ Weakness due to renal dysfunction
☐ Limitation of exertion due to renal dysfunction
☐ Able to perform only sedentary activity, due to persistent edema caused by renal dysfunction
☐ Markedly decreased function other organ systems, especially the cardiovascular system, caused by renal dysfunction
If checked, describe: _____
☐ Other, describe: _____

c. Does the Veteran have hypertension and/or heart disease due to renal dysfunction or caused by any kidney condition?
☐ Yes ☐ No
If yes, also complete the Hypertension and/or Heart Disease Questionnaire as appropriate.

4. Urolithiasis
Does the Veteran now have or has he/she ever had kidney, ureteral or bladder calculi (urolithiasis)?
☐ Yes ☐ No
If yes, complete the following section:

a. Indicate current/past location of calculi (check all that apply)
☐ Kidney ☐ Ureter ☐ Bladder

b. Has the Veteran had treatment for recurrent stone formation in the kidney, ureter or bladder?
☐ Yes ☐ No
If yes, indicate treatment: (check all that apply)
☐ Diet therapy
If checked, specify diet and dates of use: _____
☐ Drug therapy
If checked, list medication and dates of use: _____
☐ Invasive or non-invasive procedures
If checked, indicate average number of times per year invasive or non-invasive procedures were required:
☐ 0 to 1 per year ☐ 2 per year ☐ > 2 per year
Date and facility of most recent invasive or non-invasive procedure: _____

c. Does the Veteran have any signs or symptoms due to urolithiasis?
☐ Yes ☐ No
If yes, indicate severity (check all that apply):
☐ No symptoms or attacks of colic

☐ Occasional attacks of colic
☐ Frequent attacks of colic
☐ Causing voiding dysfunction
☐ Requires catheter drainage
☐ Causing infection (pyonephrosis)
☐ Causing hydronephrosis
☐ Causing impaired kidney function
☐ Other, describe: _____

5. Urinary tract/kidney infection

Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?
☐ Yes ☐ No
If yes, complete the following section:

a. Etiology of recurrent urinary tract or kidney infections: _____

b. Indicate all treatment modalities used for recurrent urinary tract or kidney infections (check all that apply):
☐ No treatment
☐ Long-term drug therapy
If checked, list medications used and indicate dates for courses of treatment over the past 12 months:
_____
☐ Hospitalization
If checked, indicate frequency of hospitalization:
☐ 1 or 2 per year
☐ > 2 per year
☐ Drainage
If checked, indicate dates when drainage performed over past 12 months: _____
☐ Continuous intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
☐ Intermittent intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
☐ Other, describe: _____

6. Kidney transplant or removal

Has the Veteran had a kidney transplant or removal?
☐ Yes ☐ No
If yes, complete the following section:

a. Has the Veteran had a kidney removed?
☐ Yes ☐ No
If yes, provide reason:
☐ Kidney donation
☐ Due to disease
☐ Due to trauma or injury
☐ Other, describe: _____

b. Has the Veteran had a kidney transplant?
☐ Yes ☐ No
If yes, date of transplant: _____
Name of treatment facility, dates of admission and date of discharge for transplant: _____

7. Tumors and neoplasms

a. Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?
☐ Yes ☐ No
If yes, complete the following section:

b. Is the neoplasm
☐ Benign ☐ Malignant

c. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?
☐ Yes ☐ No; watchful waiting
If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):
☐ Treatment completed; currently in watchful waiting status
☐ Surgery
If checked, describe: _____
Date(s) of surgery: _____
☐ Radiation therapy
Date of most recent treatment: _____
Date of completion of treatment or anticipated date of completion: _____
☐ Antineoplastic chemotherapy
Date of most recent treatment: _____
Date of completion of treatment or anticipated date of completion: _____ _____
☐ Other therapeutic procedure
If checked, describe procedure: _____
Date of most recent procedure: _____
☐ Other therapeutic treatment
If checked, describe treatment:
Date of completion of treatment or anticipated date of completion: _____

d. Does the Veteran currently have any residual conditions or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?
☐ Yes ☐ No
If yes, list residual conditions and complications (brief summary): _____

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

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
☐ Yes ☐ No
If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?
☐ Yes ☐ No
If yes, describe (brief summary): _____

9. Diagnostic testing

NOTE: If laboratory test results are in the medical record and reflect the Veteran's current renal function, repeat testing is not required. Provide testing completed appropriate to Veteran's condition; testing indicated below is not indicated for every kidney condition.

a. Has the Veteran had laboratory or other diagnostic studies performed?
☐ Yes ☐ No
If yes, provide most recent results, if available:

b. Laboratory studies

☐ BUN:	Date: _____	Result: _____
☐ Creatinine:	Date: _____	Result: _____
☐ EGFR:	Date: _____	Result: _____

c. Urinalysis:

☐ Hyaline casts:	Date: _____	Result: _____
☐ Granular casts:	Date: _____	Result: _____
☐ RBC's/HPF:	Date: _____	Result: _____
☐ Proteinuria (albumin):	Date: _____	Result: _____
☐ Spot urine for protein/creatinine ratio:		
	Date: _____	Result: _____
☐ 24 hour protein (mg/day):	Date: _____	Result: _____

d. Spot urine microalbumin/creatinine: Date: _____ Result: _____

e. Are there any other significant diagnostic test findings and/or results?
☐ Yes ☐ No
If yes, provide type of test or procedure, date and results (brief summary): _____

10. Functional impact
Does the Veteran's kidney condition(s), including neoplasms, if any, impact his or her ability to work?
☐ Yes ☐ No
If yes, describe impact of each of the Veteran's kidney conditions, providing one or more examples: ____

11. Remarks, if any: _____

Physician signature: _____ Date: ___
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

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

6.4. DBQ Male Reproductive System Conditions

Name of patient/Veteran: _____SSN: _____

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

1. Diagnosis:

Does the Veteran now have or has he ever been diagnosed with any conditions of the male reproductive system? ☐ Yes ☐ No

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

- ☐ Erectile dysfunction ICD code: _____ Date of diagnosis: _____
- ☐ Penis, deformity (e.g., Peyronie's) ICD code: _____ Date of diagnosis: _____
- ☐ Testis, atrophy, one or both ICD code: _____ Date of diagnosis: _____
- ☐ Testis, removal, one or both ICD code: _____ Date of diagnosis: _____
- ☐ Epididymitis, chronic ICD code: _____ Date of diagnosis: _____
- ☐ Epididymo-orchitis, chronic ICD code: _____ Date of diagnosis: _____
- ☐ Prostate injury ICD code: _____ Date of diagnosis: _____
- ☐ Prostate hypertrophy (BPH) ICD code: _____ Date of diagnosis: _____
- ☐ Prostatitis, chronic ICD code: _____ Date of diagnosis: _____
- ☐ Prostate surgical residuals (as addressed in items 3-6) ICD code: _____ Date of diagnosis: _____
- ☐ Neoplasms of the male reproductive system ICD code: _____ Date of diagnosis: _____
- ☐ Other male reproductive system condition (specify diagnosis, providing only diagnoses that pertain to male reproductive system.) ICD code: _____ Date of diagnosis: _____

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

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

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

2. Medical history

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

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

c. Has the Veteran had an orchiectomy?
☐ Yes ☐ No
Indicate testicle removed: ☐ Right ☐ Left ☐ Both
Indicate reason for removal:
☐ Undescended
☐ Congenitally underdeveloped
☐ Other, provide reason for removal: _____

3. Voiding dysfunction
Does the Veteran have a voiding dysfunction?
☐ Yes ☐ No
If yes, complete the following section:

a. Etiology of voiding dysfunction: _____

b. Does the voiding dysfunction cause urine leakage?
☐ Yes ☐ No
Indicate severity (check one):
☐ Does not require the wearing of absorbent material
☐ Requires absorbent material which must be changed less than 2 times per day
☐ Requires absorbent material which must be changed 2 to 4 times per day
☐ Requires absorbent material which must be changed more than 4 times per day
☐ Other, describe: _____

c. Does the voiding dysfunction require the use of an appliance?
☐ Yes ☐ No
If yes, describe the appliance: _____

d. Does the voiding dysfunction cause increased urinary frequency?
☐ Yes ☐ No
If yes, check all that apply:
☐ Daytime voiding interval between 2 and 3 hours
☐ Daytime voiding interval between 1 and 2 hours
☐ Daytime voiding interval less than 1 hour
☐ Nighttime awakening to void 2 times
☐ Nighttime awakening to void 3 to 4 times
☐ Nighttime awakening to void 5 or more times

e. Does the voiding dysfunction cause signs or symptoms of obstructed voiding?
☐ Yes ☐ No
If yes, check all that apply:
☐ Hesitancy
If checked, is hesitancy marked?
☐ Yes ☐ No
☐ Slow or weak stream
If checked, is stream markedly slow or weak?
☐ Yes ☐ No
☐ Decreased force of stream
If checked, is force of stream markedly decreased?
☐ Yes ☐ No
☐ Stricture disease requiring dilatation 1 to 2 times per year
☐ Stricture disease requiring periodic dilatation every 2 to 3 months
☐ Recurrent urinary tract infections secondary to obstruction
☐ Uroflowmetry peak flow rate less than 10 cc/sec
☐ Post void residuals greater than 150 cc
☐ Urinary retention requiring intermittent catheterization

☐ Urinary retention requiring continuous catheterization
☐ Other, describe: _____

4. Urinary tract/kidney infection
Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?
☐ Yes ☐ No
If yes, complete the following section:

a. Etiology of recurrent urinary tract or kidney infections: _____

b. Indicate all treatment modalities used for recurrent urinary tract or kidney infections (check all that apply):
☐ No treatment
☐ Long-term drug therapy
If checked, list medications used and indicate dates for courses of treatment over the past 12 months:
_____
☐ Hospitalization
If checked, indicate frequency of hospitalization:
☐ 1 or 2 per year
☐ >2 per year
☐ Drainage
If checked, indicate dates when drainage performed over past 12 months: _____
☐ Continuous intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
☐ Intermittent intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
☐ Other, describe: _____

5. Erectile dysfunction
Does the Veteran have erectile dysfunction?
☐ Yes ☐ No
If yes, complete the following section:

a. Etiology of erectile dysfunction: _____

b. If the Veteran has erectile dysfunction, is it as likely as not (at least a 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?
☐ Yes ☐ No
If yes, specify the diagnosis to which the erectile dysfunction is as likely as not attributable: _____

c. If the Veteran has erectile dysfunction, is he able to achieve an erection sufficient for penetration and ejaculation (without medication)?
☐ Yes ☐ No
If no, is the Veteran able to achieve an erection sufficient for penetration and ejaculation (with medication)?
☐ Yes ☐ No

6. Retrograde ejaculation
Does the Veteran have retrograde ejaculation?
☐ Yes ☐ No
If yes, complete the following section:

a. Etiology of retrograde ejaculation: _____

b. If the Veteran has retrograde ejaculation, is it as likely as not (at least a 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?
☐ Yes ☐ No
If yes, specify the diagnosis to which the retrograde ejaculation is as likely as not attributable: _____

7. Male reproductive organ infections

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

☐ Yes ☐ No

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

- ☐ No treatment
- ☐ Long-term drug therapy
  - If checked, list medications used and indicate dates for courses of treatment over the past 12 months: _____
- ☐ Hospitalization

If checked, indicate frequency of hospitalization:

- ☐ 1 or 2 per year
- ☐ > 2 per year

- ☐ Continuous intensive management
  - If checked, indicate types of treatment and medications used over past 12 months: _____
- ☐ Intermittent intensive management
  - If checked, indicate types of treatment and medications used over past 12 months: _____
- ☐ Other, describe: _____

8. Physical exam

a. Penis

- ☐ Normal
- ☐ Not examined per Veteran's request
- ☐ Not examined per Veteran's request; Veteran reports normal anatomy with no penile deformity or abnormality
- ☐ Not examined; penis exam not relevant to condition
- ☐ Abnormal

If abnormal, indicate severity:

- ☐ Loss/removal of half or more of penis
- ☐ Loss/removal of glans penis
- ☐ Penis deformity (such as Peyronie's disease)
  - If checked, describe: _____

b. Testes

- ☐ Normal
- ☐ Not examined per Veteran's request
- ☐ Not examined per Veteran's request; Veteran reports normal anatomy with no testicular deformity or abnormality
- ☐ Not examined; testicular exam not relevant to condition
- ☐ Abnormal
  - If abnormal, check all that apply:

Right testicle

- ☐ Size 1/3 or less of normal
- ☐ Size 1/2 to 1/3 of normal
- ☐ Considerably harder than normal
- ☐ Considerably softer than normal
- ☐ Absent
- ☐ Other abnormality,
  - Describe: _____

Left testicle

- ☐ Size 1/3 or less of normal
- ☐ Size 1/2 to 1/3 of normal

☐ Considerably harder than normal
☐ Considerably softer than normal
☐ Absent
☐ Other abnormality,
Describe: _____

c. Epididymis
☐ Normal
☐ Not examined per Veteran's request
☐ Not examined per Veteran's request; Veteran reports normal anatomy of epididymis with no deformity or abnormality
☐ Not examined; epididymis exam not relevant to condition
☐ Abnormal

If abnormal, check all that apply:
Right epididymis
☐ Tender to palpation
☐ Other, describe: _____

Left epididymis
☐ Tender to palpation
☐ Other, describe: _____

d. Prostate
☐ Normal
☐ Not examined per Veteran's request
☐ Not examined; prostate exam not relevant to condition
☐ Abnormal
If abnormal, describe: _____

9. Tumors and neoplasms

Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?
☐ Yes ☐ No
If yes, complete the following section:

a. Is the neoplasm
☐ Benign ☐ Malignant

b. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?
☐ Yes ☐ No; watchful waiting
If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):
☐ Treatment completed; currently in watchful waiting status
☐ Surgery
If checked, describe: _____
Date(s) of surgery: _____
☐ Radiation therapy
Date of most recent treatment: _____
Date of completion of treatment or anticipated date of completion: _____
☐ Antineoplastic chemotherapy
Date of most recent treatment: _____
Date of completion of treatment or anticipated date of completion: _____ _____
☐ Other therapeutic procedure
If checked, describe procedure: _____
Date of most recent procedure: _____

☐ Other therapeutic treatment
If checked, describe treatment:
Date of completion of treatment or anticipated date of completion: _____

c. Does the Veteran currently have any residual conditions or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?
☐ Yes ☐ No
If yes, list residual conditions and complications (brief summary): _____

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

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

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
☐ Yes ☐ No
If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?
☐ Yes ☐ No
If yes, describe (brief summary): _____

11. Diagnostic testing

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

a. Has a testicular biopsy been performed?
☐ Yes ☐ No
Date of biopsy: _____
Resutls:
☐ Spermatozoa present
☐ Other, describe: _____

b. Have any other imaging studies, diagnostic procedures or laboratory testing been performed and are the results available?
☐ Yes ☐ No
If yes, provide type of test or procedure, date and results (brief summary): _____

12. Functional impact

Does the Veteran's male reproductive system condition(s), including neoplasms, if any, impact his ability to work?
☐ Yes ☐ No
If yes, describe the impact of each of the Veteran's male reproductive system condition(s), providing one or more examples:_____

13. Remarks, if any: _____

Physician signature: _____ Date: ___
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

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

6.5. DBQ Prostate Cancer

Name of patient/Veteran: _____SSN: _____

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

1. Diagnosis

Does the Veteran now have or has he ever been diagnosed with prostate cancer?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to prostate cancer.
Diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____

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

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

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

2. Medical history

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

b. Indicate status of disease:
☐ Active
☐ Remission

3. Treatment

Has the Veteran completed any treatment for prostate cancer or is the Veteran currently undergoing any treatment for prostate cancer?
☐ Yes ☐ No; watchful waiting
If yes, indicate treatment type(s) (check all that apply):
☐ Treatment completed; currently in watchful waiting status
☐ Surgery
☐ Prostatectomy
☐ Radical prostatectomy
☐ Transurethral resection prostatectomy
☐ Other (describe)_____
☐ Other surgical procedure (describe): _____
Date of surgery: _____
☐ Radiation therapy
Date of completion of treatment or anticipated date of completion: _____
☐ Brachytherapy
Date of treatment: _____

☐ Antineoplastic chemotherapy
Date of completion of treatment or anticipated date of completion: _____
☐ Androgen deprivation therapy (hormonal therapy)
Date of completion of treatment or anticipated date of completion: _____
☐ Other therapeutic procedure and/or treatment (describe): _____
Date of procedure: _____
Date of completion of treatment or anticipated date of completion: _____

4. Voiding dysfunction

Does the Veteran have a voiding dysfunction?
☐ Yes ☐ No
If yes, provide etiology of voiding dysfunction: _____
If the Veteran has a voiding dysfunction, complete the following questions:

a. Does the voiding dysfunction cause urine leakage?
☐ Yes ☐ No
Indicate severity (check one):
☐ Does not require the wearing of absorbent material
☐ Requires absorbent material which must be changed less than 2 times per day
☐ Requires absorbent material which must be changed 2 to 4 times per day
☐ Requires absorbent material which must be changed more than 4 times per day
☐ Other, describe: _____

b. Does the voiding dysfunction require the use of an appliance?
☐ Yes ☐ No
If yes, describe the appliance: _____

c. Does the voiding dysfunction cause increased urinary frequency?
☐ Yes ☐ No
If yes, check all that apply:
☐ Daytime voiding interval between 2 and 3 hours
☐ Daytime voiding interval between 1 and 2 hours
☐ Daytime voiding interval less than 1 hour
☐ Nighttime awakening to void 2 times
☐ Nighttime awakening to void 3 to 4 times
☐ Nighttime awakening to void 5 or more times

d. Does the voiding dysfunction cause signs or symptoms of obstructed voiding?
☐ Yes ☐ No
If yes, check all that apply:
☐ Hesitancy
If checked, is hesitancy marked?
☐ Yes ☐ No
☐ Slow or weak stream
If checked, is stream markedly slow or weak?
☐ Yes ☐ No
☐ Decreased force of stream
If checked, is force of stream markedly decreased?
☐ Yes ☐ No
☐ Stricture disease requiring dilatation 1 to 2 times per year
☐ Stricture disease requiring periodic dilatation every 2 to 3 months
☐ Recurrent urinary tract infections secondary to obstruction
☐ Uroflowmetry peak flow rate less than 10 cc/sec
☐ Post void residuals greater than 150 cc
☐ Urinary retention requiring intermittent catheterization
☐ Urinary retention requiring continuous catheterization

☐ Other, describe: _____

5. Urinary tract/kidney infection

Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?
☐ Yes ☐ No
If yes, provide etiology: _____

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

☐ No treatment
☐ Long-term drug therapy
If checked, list medications used and indicate dates for courses of treatment over the past 12 months:
_____
☐ Hospitalization
If checked, indicate frequency of hospitalization:
☐ 1 or 2 per year
☐ > 2 per year
☐ Drainage
If checked, indicate dates when drainage performed over past 12 months: _____
☐ Continuous intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
☐ Intermittent intensive management
If checked, indicate types of treatment and medications used over past 12 months: _____
☐ Other, describe: _____

6. Erectile dysfunction

a. Does the Veteran have erectile dysfunction?
☐ Yes ☐ No
If yes, provide etiology: _____

b. If the Veteran has erectile dysfunction, is it as likely as not (at least a 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?
☐ Yes ☐ No
If yes, specify the diagnosis to which the erectile dysfunction is as likely as not attributable: _____

c. If the Veteran has erectile dysfunction, is he able to achieve an erection sufficient for penetration and ejaculation (without medication)?
☐ Yes ☐ No
If no, is the Veteran able to achieve an erection sufficient for penetration and ejaculation (with medication)?
☐ Yes ☐ No

7. Retrograde ejaculation

a. Does the Veteran have retrograde ejaculation?
☐ Yes ☐ No
If yes, provide etiology of the retrograde ejaculation: _____

b. If the Veteran has retrograde ejaculation, is it as likely as not (at least a 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?
☐ Yes ☐ No
If yes, specify the diagnosis to which the retrograde ejaculation is as likely as not attributable: _____

8. Residual conditions and/or complications

a. Does the Veteran have any other residual conditions and/or complications due to prostate cancer or treatment for prostate cancer?
☐ Yes ☐ No
If yes, describe: _____

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

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

☐ Yes ☐ No

If yes, describe (brief summary): _____

10. Diagnostic testing

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

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

☐ Yes ☐ No

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

11. Functional impact

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

☐ Yes ☐ No

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

12. Remarks, if any: _____

Physician signature: _____ Date: ___

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

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

6.6. DBQ Skin Diseases

Name of patient/Veteran: _____SSN: _____

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

1. Diagnosis:

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

☐ Yes ☐ No

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

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

☐ Dermatitis or eczema
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Infectious skin conditions (including bacterial, fungal, viral, treponemal and parasitic skin conditions)
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Bullous disorders
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Psoriasis ICD code: _____ Date of diagnosis: _____

☐ Exfoliative dermatitis (erythroderma) ICD code: _____ Date of diagnosis: _____

☐ Cutaneous manifestations of collagen-vascular diseases
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Papulosquamous skin disorders
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Vitiligo
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Keratinization skin disorders
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Urticaria
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Primary cutaneous vasculitis

☐ Erythema multiforme ICD code: _____ Date of diagnosis: _____

☐ Acne ICD code: _____ Date of diagnosis: _____

☐ Chloracne ICD code: _____ Date of diagnosis: _____

☐ Alopecia ICD code: _____ Date of diagnosis: _____

☐ Hyperhidrosis ICD code: _____ Date of diagnosis: _____

☐ Tumors and neoplasms of the skin, including malignant melanoma
Diagnosis: _____ ICD code: _____ Date of diagnosis: _____

☐ Other skin condition
Other diagnosis #1: _____ ICD code: _____ Date of diagnosis: _____
Other diagnosis #2: _____ ICD code: _____ Date of diagnosis: _____
Other diagnosis #3: _____ ICD code: _____ Date of diagnosis: _____

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

2. Medical History

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

b. Do any of the Veteran's skin conditions cause scarring or disfigurement of the head, face or neck?
☐ Yes ☐ No
If yes, indicate skin condition and describe scarring and/or disfigurement: _____
Also complete the Scars Questionnaire if appropriate.

c. Does the Veteran have any benign or malignant skin neoplasms (including malignant melanoma)?
☐ Yes ☐ No

d. Does the Veteran have any systemic manifestations due to any skin diseases (such as fever, weight loss or hypoproteinemia associated with skin conditions such as erythroderma)?
☐ Yes ☐ No
If yes, describe: _____
Also complete additional Questionnaires if appropriate.

3. Treatment

a. Has the Veteran been treated with oral or topical medications in the past 12 months for any skin condition?
☐ Yes ☐ No
If yes, check all that apply:

☐ Systemic corticosteroids or other immunosuppressive medications
If checked, list medication(s): _____
Specify condition medication used for: _____
Total duration of medication use in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Antihistamines
If checked, list medication(s): _____
Specify condition medication used for: _____
Total duration of medication use in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Immunosuppressive retinoids
If checked, list medication(s): _____
Specify condition medication used for: _____
Total duration of medication use in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Sympathomimetics
If checked, list medication(s): _____
Specify condition medication used for: _____
Total duration of medication use in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Other oral medications
If checked, list medication(s): _____
Specify condition medication used for: _____
Total duration of medication use in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Topical corticosteroids
If checked, list medication(s): _____
Specify condition medication used for: _____
Total duration of medication use in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Other topical medications
If checked, list medication(s): _____
Specify condition medication used for: _____
Total duration of medication use in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

NOTE: If a medication is used for more than one condition, provide names of all conditions, name of medication used for each condition, and frequency of use for each condition: _____

b. Has the Veteran had any treatments or procedures other than systemic or topical medications in the past 12 months for exfoliative dermatitis or papulosquamous disorders?
☐ Yes ☐ No
If yes, check all that apply:
☐ PUVA (photo-chemotherapy with psoralen and ultraviolet A) treatment
If checked, specify condition treated: _____
Date of most recent treatment: _____
Total duration of treatment in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant
☐ UVB (ultraviolet B phototherapy) treatment
If checked, specify condition treated: _____
Date of most recent treatment: _____
Total duration of treatment in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant
☐ Electron beam therapy
If checked, specify condition treated: _____
Date of most recent treatment: _____
Total duration of treatment in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant
☐ Intensive light therapy
If checked, specify condition treated: _____
Date of most recent treatment: _____
Total duration of treatment in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant
☐ Other treatment
Specify treatment: _____
Specify condition treated: _____
Date of most recent treatment: _____
Total duration of treatment in past 12 months:
☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

4. Debilitating and non-debilitating episodes

a. Has the Veteran had any debilitating episodes in the past 12 months due to urticaria, primary cutaneous vasculitis, erythema multiforme, or toxic epidermal necrolysis?
☐ Yes ☐ No
If yes, specify condition causing debilitating episodes:
☐ urticaria ☐ primary cutaneous vasculitis ☐ erythema multiforme ☐ toxic epidermal necrolysis
Describe debilitating episodes (brief summary): _____
Number of debilitating episodes in past 12 months:
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
Characteristics of debilitating episodes
☐ Occurred despite ongoing immunosuppressive therapy
☐ Required treatment with intermittent systemic immunosuppressive therapy
☐ Responded to treatment with antihistamines or sympathomimetics

b. Has the Veteran had any non-debilitating episodes of urticaria, primary cutaneous vasculitis, erythema multiforme, or toxic epidermal necrolysis in the past 12 months?

☐ Yes ☐ No
If yes, specify condition causing non-debilitating episodes:
☐ urticaria ☐ primary cutaneous vasculitis ☐ erythema multiforme ☐ toxic epidermal necrolysis
Describe episodes (brief summary): _____
Number of non-debilitating episodes in past 12 months:
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
Characteristics of non-debilitating episodes
☐ Occurred despite ongoing immunosuppressive therapy
☐ Required treatment with intermittent systemic immunosuppressive therapy
☐ Responded to treatment with antihistamines or sympathomimetics

NOTE: If the Veteran's debilitating and/or non-debilitating episodes are due to more than one condition, provide names of all conditions, indicating severity and frequency of episodes for each condition: _____

5. Physical exam
a. Indicate the Veteran's visible skin conditions; indicate the approximate total body area and approximate total EXPOSED body area (face, neck and hands) affected on current examination (check all that apply):

☐ Dermatitis	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
☐ Eczema	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
☐ Bullous disorder	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
☐ Psoriasis	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
☐ Infections of the skin						
	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
☐ Cutaneous manifestations of collagen-vascular disease						
	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
☐ Papulosquamous disorder						
	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ > 40%

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

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

6. Specific Skin Conditions
Indicate the Veteran's specific skin conditions and complete all applicable subsequent questions (check all that apply):
☐ Acne or Chloracne
If checked, indicate severity and location (check all that apply):
☐ Superficial acne (comedones, papules, pustules, superficial cysts) of any extent
☐ Deep acne (deep inflamed nodules and pus-filled cysts)
☐ Affects less than 40% of face and neck
☐ Affects 40% or more of face and neck
☐ Affects body areas other than face and neck

☐ Vitiligo
If checked, indicate areas affected by vitiligo:
☐ Exposed areas affected
☐ No exposed areas affected

☐ Scarring alopecia
If checked, indicate percent of scalp affected:
☐ < 20 % ☐ 20 to 40% ☐ > 40%

☐ Alopecia areata
If checked, indicate amount of hair loss:
☐ Hair loss limited to scalp and face ☐ Loss of all body hair
☐ Other, describe: _____

☐ Hyperhidrosis
If checked, indicate severity:
☐ Able to handle paper or tools after treatment
☐ Unresponsive to treatment; unable to handle paper or tools

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

7. Tumors and neoplasms

a. Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?
☐ Yes ☐ No
If yes, complete the following:

b. Is the neoplasm
☐ Benign ☐ Malignant

c. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?
☐ Yes ☐ No; watchful waiting
If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):
☐ Treatment completed; currently in watchful waiting status
☐ Surgery
If checked, describe: _____
Date(s) of surgery: _____
☐ Radiation therapy
Date of most recent treatment: _____
Date of completion of treatment or anticipated date of completion: _____
☐ Antineoplastic chemotherapy
Date of most recent treatment: _____
Date of completion of treatment or anticipated date of completion: _____ _____
☐ Other therapeutic procedure
If checked, describe procedure: _____
Date of most recent procedure: _____
☐ Other therapeutic treatment
If checked, describe treatment: _____
Date of completion of treatment or anticipated date of completion: _____

d. Does the Veteran currently have any residual conditions or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?
☐ Yes ☐ No
If yes, list residual conditions and complications (brief summary): _____

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

8. Other pertinent physical findings, complications, conditions, signs and/or symptoms
Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any conditions listed in the Diagnosis section above?
☐ Yes ☐ No
If yes, describe: _____

9. Functional impact
Do any of the Veteran's skin conditions impact his or her ability to work?
☐ Yes ☐ No
If yes, describe impact of each of the Veteran's skin conditions, providing one or more examples: _____

10. Remarks, if any: _____

Physician signature: _____ Date: ___
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

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

7. Software and Documentation Retrieval

7.1 Software

The VistA software is being distributed as a PackMan patch message through the National Patch Module (NPM). The KIDS build for this patch is DVBA*2.7*169.

7.2 User Documentation

The user documentation for this patch may be retrieved directly using FTP. The preferred method is to FTP the files from:

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_P169_RN.PDF	Binary	Release Notes
DVBA_27_P169_DBQ_HAIRYCELLLEUKEMIAS_WF.DOCX	Binary	Workflow Document
DVBA_27_P169_DBQ_HEARINGLOSSTINNITUS._WF.DOCX	Binary	Workflow Document
DVBA_27_P169_DBQ_ HEMICANDLYMPHATIC.WF.DOCX	Binary	Workflow Document
DVBA_27_P169_DBQ_KIDNEYCONDITIONS_WF.DOCX	Binary	Workflow Document
DVBA_27_P169_DBQ_MALEREPRODUCTIVE_WF.DOCX	Binary	Workflow Document
DVBA_27_P169_DBQ_PROSTATECANCER_WF.DOCX	Binary	Workflow Document

7.3 Related Documents

The VistA Documentation Library (VDL) web site will also contain the DVBA*2.7*169 Release Notes and Workflow documents. This web site is usually updated within 1-3 days of the patch release date.

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

Content and/or changes to the DBQs is communicated by the Disability Examination Management Office (DEMO) through: http://vbacodmoint1.vba.va.gov/bl/21/DBQ/default.asp