

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

August 2011

Department of Veterans Affairs

Office of Enterprise Development

Management & Financial Systems

**Preface**

**Purpose of the Release Notes**

The Release Notes document describes the new features and functionality of patch DVBA\*2.7\*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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# 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).

# 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 (INCUDING 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**

# Associated Remedy Tickets & New Service Requests

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

# 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 (INCUDING 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 l

Paramyoclonus multiplex (convulsive state, myoclonic type)

Tic, convulsive (Gilles de la Tourette syndrome)

Dystonia, specify type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Essential tremor

Tardive dyskenesia or other neuroleptic induced syndromes

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

Neuromuscular disorders

Myasthenia gravis

Myasthenic syndrome

Botulism

Hereditary muscular disorders specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Familial periodic paralysis

Myoglobulinuria

Dermatomyositis or polyomiositis, 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:  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

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 symptomotology 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)

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

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

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

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

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

\_\_\_ 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):

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

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

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

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

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

Total or partial pancreatectomy ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

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

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

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):

Migraine including migraine variants ICD code: \_\_\_ Date of diagnosis: \_\_\_\_

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

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

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):

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

Intestinal distomiasis (intestinal fluke) ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Parasitic infection of the intestines ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

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.

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## 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, indicatefindings: (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.

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## 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):

Hepatitis A ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ (complete Section I)

Hepatitis B ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ (complete Section I)

Hepatitis C ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ (complete Section I)

Autoimmune hepatitis ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ (complete Section I)

Drug-induced hepatitis ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ (complete Section I)

Hemochromatosis ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ (complete Section I)

Cirrhosis of the liver ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ (complete Section II)

Primary biliary cirrhosis ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ (complete Section II)

Sclerosing cholangitis ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ (complete Section II)

Liver transplant candidate ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ (complete Section III)

Liver transplant ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ (complete Section III)

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:

Recombinant immunoblot assay (RIBA)

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

Hepatitis C genotype Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis C viral titers Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Alkaline phosphatase Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

INR (PT) Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

MELD score Date: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

l. 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: \_\_\_\_\_\_\_\_

Gonorrheal arthritis ICD code(s): \_\_\_\_\_\_\_\_\_\_Date of diagnosis: \_\_\_\_\_\_\_\_

Pneumococcic arthritis ICD code(s): \_\_\_\_\_\_\_\_\_\_Date of diagnosis: \_\_\_\_\_\_\_\_

Typhoid arthritis ICD code(s): \_\_\_\_\_\_\_\_\_\_Date of diagnosis: \_\_\_\_\_\_\_\_

Syphilitic arthritis ICD code(s): \_\_\_\_\_\_\_\_\_\_Date of diagnosis: \_\_\_\_\_\_\_\_

Streptococcic 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](http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0003817) Date of test: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete blood count (CBC)

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

C-reactive protein ([CRP](http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0003836)) Date of test: \_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Erythrocyte sedimentation rate ([ESR](http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0004104))

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.

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## 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 distension

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):

Internal or external hemorrhoids ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_

Anal/perianal fistula ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_

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

Impairment of rectal sphincter control ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_

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

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

Other, specify below:

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

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

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

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

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

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

If there are additional diagnoses that pertain to 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):

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

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

Stenosis of the stomach ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

Marginal (gastrojejunal) ulcer ICD code: \_\_\_\_\_\_ Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_

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

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

Status post vagotomy with pyloroplasty

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

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

Peritoneal adhesions following injury or surgery of the stomach

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

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

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

**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:

**REDACTED**

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

directly from a specific server as follows:

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

|  |  |  |
| --- | --- | --- |
| **File Name** | **Format** | **Description** |
| **DVBA\_27\_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>