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.
# Table of Contents

1. Purpose ......................................................................................... 1

2. Overview ...................................................................................... 1

3. Associated Remedy Tickets & New Service Requests .................. 2

4. Defects Fixes ............................................................................... 2

5. Enhancements ............................................................................. 2

   5.1. CAPRI – DBQ Template Additions ................................................. 2
   5.2. AMIE-DBQ Worksheet Additions .................................................. 3
   5.3. CAPRI Template Defects ................................................................. 4

6. Disability Benefits Questionnaires (DBQs) ................................. 5

   6.1. DBQ Breast Conditions and Disorders ........................................... 5
   6.2. DBQ Central Nervous System and Neuromuscular Diseases ............ 8
   6.3. DBQ Ear Conditions (Including Vestibular and Infectious Conditions) ......................... 17
   6.4. DBQ Esophageal Conditions (including gastroesophageal reflux disease (GERD), hiatal hernia and other esophageal disorders) ........................................... 22
   6.5. DBQ Gallbladder and Pancreas Conditions ..................................... 26
   6.6. DBQ Gynecological Conditions ...................................................... 30
   6.7. DBQ Headaches (including Migraine Headaches) ............................ 36
   6.8. DBQ Infectious Intestinal Disorders, Including bacterial and parasitic infections .......... 39
   6.9. DBQ Intestinal Surgery (bowel resection, colostomy and ileostomy) .......... 42
   6.10. DBQ Intestinal Conditions (other than Surgical or Infectious), including irritable bowel syndrome, Crohn’s disease, ulcerative colitis and diverticulitis ............................................... 45
   6.11. DBQ Hepatitis, Cirrhosis and other Liver Conditions ..................... 49
   6.12. DBQ Multiple Sclerosis (MS) .......................................................... 54
   6.13. DBQ Non-Degenerative Arthritis (Including inflammatory, autoimmune, crystalline and infectious arthritis) and Dysbaric Osteonecrosis ........................................... 65
   6.14. DBQ Osteomyelitis ....................................................................... 71
   6.15. DBQ Peritoneal Adhesions ............................................................. 76
   6.16. DBQ Rectum and Anus Conditions (including Hemorrhoids) ............ 79
   6.17. DBQ Sleep Apena ........................................................................ 83
   6.18. DBQ Stomach and Duodenal Conditions (Not including GERD esophageal disorders) ............. 85

7. Software and Documentation Retrieval ......................................... 90

   7.1 Software .................................................................................. 90
   7.2 User Documentation ................................................................. 90
   7.3 Related Documents .................................................................. 90
1. Purpose

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

Patch DVBA *2.7*174 (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs) introduces enhancements and updates made to the AUTOMATED MED INFO EXCHANGE (AMIE) V 2.7 package and the Compensation & Pension Record Interchange (CAPRI) application in support of the new Compensation and Pension (C&P) Disability Benefits Questionnaires (DBQs).

2. Overview

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

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

3. Associated Remedy Tickets & New Service Requests

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

4. Defects Fixes

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

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

5. Enhancements

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

5.1. CAPRI – DBQ Template Additions

This patch includes adding new CAPRI DBQ Templates that are accessible through the Compensation and Pension Worksheet Module (CPWM) of the CAPRI GUI application.

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

- **DBQ BREAST CONDITIONS AND DISORDERS**
- DBQ CENTRAL NERVOUS SYSTEM AND NEUROMUSCULAR DISEASES (EXCEPT TBI, ALS, PD, MS, HEADACHES, TMJ, EPILEPSY, NARCOLEPSY, PN, SA, CND, FIBROMYALGIA, AND CFS)
- DBQ EAR CONDITIONS
- DBQ ESOPHAGEAL CONDITIONS (INCLUDING GASTROESOPHAGEAL REFLUX DISEASE (GERD), HIATAL HERNIA AND OTHER ESOPHAGEAL DISORDERS)
- DBQ GALLBLADDER AND PANCREAS CONDITIONS
- DBQ GYNECOLOGICAL CONDITIONS
- DBQ HEADACHES (INCLUDING MIGRAINE HEADACHES)
- DBQ HEPATITIS, CIRRHOSIS AND OTHER LIVER CONDITIONS
- DBQ INFECTIOUS INTESTINAL DISORDERS, INCLUDING BACTERIAL AND PARASITIC INFECTIONS
- DBQ INTESTINAL CONDITIONS (OTHER THAN SURGICAL OR INFECTIOUS), INCLUDING IRRITABLE BOWEL SYNDROME, CROHN'S DISEASE, ULCERATIVE COLITIS AND DIVERTICULITIS
- DBQ INTESTINAL SURGERY (BOWEL RESECTION, COLOSTOMY AND ILEOSTOMY)
- DBQ MULTIPLE SCLEROSIS (MS)
- DBQ NON-DEGENERATIVE ARTHRITIS (INCLUDING INFLAMMATORY AUTOIMMUNE, CRYSTALLINE AND INFECTIOUS ARTHRITIS) AND DYSBARIC OSTEONECROSIS
- DBQ OSTEOMYELITIS
- DBQ PERITONEAL ADHESIONS
- DBQ RECTUM AND ANUS CONDITIONS (INCLUDING HEMORRHHOIDS)
- 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 HEMORRHHOIDS)
- DBQ SLEEP APNEA
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: __________________________ ICCode: __________________________ Date of diagnosis #1: __________________________

Diagnosis #2: __________________________ ICCode: __________________________ Date of diagnosis #2: __________________________

Diagnosis #3: __________________________ ICCode: __________________________ 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, is or was there a benign neoplasm?
☐ Yes ☐ No

If yes, describe locations: _______________

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, 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)

<table>
<thead>
<tr>
<th>CNS infections:</th>
<th>ICD Code: _____  Date of Diagnosis: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningitis</td>
<td>Specify organism: __________________________</td>
</tr>
<tr>
<td>Brain abscess</td>
<td>Specify organism: __________________________</td>
</tr>
<tr>
<td>HIV</td>
<td></td>
</tr>
<tr>
<td>Neurosyphilis</td>
<td></td>
</tr>
<tr>
<td>Lyme disease</td>
<td></td>
</tr>
<tr>
<td>Encephalitis, epidemic, chronic, including poliomyelitis, anterior (anterior horn cells)</td>
<td></td>
</tr>
<tr>
<td>Other: specify: ____________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vascular diseases</th>
<th>ICD code: _____  Date of diagnosis: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thrombosis, TIA or cerebral infarction</td>
<td></td>
</tr>
<tr>
<td>Hemorrhage, specify type: ____________</td>
<td></td>
</tr>
<tr>
<td>Cerebral arteriosclerosis</td>
<td></td>
</tr>
<tr>
<td>Other: specify: ____________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hydrocephalus</th>
<th>ICD code: _____  Date of diagnosis: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstructive</td>
<td></td>
</tr>
<tr>
<td>Communicating</td>
<td></td>
</tr>
<tr>
<td>Normal pressure (NPH)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Brain tumor</th>
<th>ICD code: _____  Date of diagnosis: ____________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Spinal Cord conditions</th>
<th>ICD code: _____  Date of diagnosis: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syringomyelia</td>
<td></td>
</tr>
<tr>
<td>Myelitis</td>
<td></td>
</tr>
<tr>
<td>Hematomyelia</td>
<td></td>
</tr>
<tr>
<td>Spinal Cord injuries</td>
<td></td>
</tr>
<tr>
<td>Radiation injury</td>
<td></td>
</tr>
<tr>
<td>Electric or lightning injury</td>
<td></td>
</tr>
<tr>
<td>Decompression sickness (DCS)</td>
<td></td>
</tr>
<tr>
<td>Other: specify: ____________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Brain Stem Conditions</th>
<th>ICD code: _____  Date of diagnosis: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulbar palsy</td>
<td></td>
</tr>
<tr>
<td>Pseudobulbar palsy</td>
<td></td>
</tr>
<tr>
<td>Other: specify: ____________</td>
<td></td>
</tr>
</tbody>
</table>
Movement disorders
- Athetosis, acquired
- Myoclonus I
- Paramyoclonus multiplex (convulsive state, myoclonic type)
- Tic, convulsive (Gilles de la Tourette syndrome)
- Dystonia, specify type: _______________
- Essential tremor
- Tardive dyskinesia or other neuroleptic induced syndromes
- Other: specify: _______________

Neuromuscular disorders
- Myasthenia gravis
- Myasthenic syndrome
- Botulism
- Hereditary muscular disorders specify: _______________
- Familial periodic paralysis
- Myoglobulinuria
- Dermatomyositis or polymiositis, 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 aphonie  
☐ 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 symptomatology or neurologic effects above are caused by each

diagnosis?

☐ Yes  ☐ No
If yes, list which symptoms or neurologic effects are attributable to each diagnosis, where possible:
_____________________________________________________________________________________

9. Assistive devices
a. Does the Veteran use any assistive device(s) as a normal mode of locomotion, although occasional locomotion
by other methods may be possible?
☐ Yes  ☐ No
If yes, identify assistive device(s) used (check all that apply and indicate frequency):

☐ Wheelchair  Frequency of use:  ☐ Occasional  ☐ Regular  ☐ Constant
☐ Brace(s)  Frequency of use:  ☐ Occasional  ☐ Regular  ☐ Constant
☐ Crutch(es)  Frequency of use:  ☐ Occasional  ☐ Regular  ☐ Constant
☐ Cane(s)  Frequency of use:  ☐ Occasional  ☐ Regular  ☐ Constant
☐ Walker  Frequency of use:  ☐ Occasional  ☐ Regular  ☐ Constant
☐ Other: ___________________________________________  Frequency of use:  ☐ Occasional  ☐ Regular  ☐ Constant

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

10. Remaining effective function of the extremities
Due to a CNS condition, is there functional impairment of an extremity such that no effective function remains other
than that which would be equally well served by an amputation with prosthesis? (Functions of the upper extremity
include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)
☐ Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.
☐ No
If yes, indicate extremity(ies) (check all extremities for which this applies):
☐ Right upper  ☐ Left upper  ☐ Right lower  ☐ Left lower
For each checked extremity, describe loss of effective function, identify the condition causing loss of function,
and provide specific examples (brief summary): _____________________________________________

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

a. Have imaging studies been performed?
☐ Yes  ☐ No
If yes, provide most recent results, if available: _________________________________________________

b. Have PFTs been performed?
☐ Yes  ☐ No
If yes, provide most recent results, if available:
FEV-1: _______  % predicted  Date of test: _____________
FEV-1/FVC: _______  % predicted  Date of test: _____________
FVC: _______  % predicted  Date of test: _____________
c. If PFTs have been performed, is the flow-volume loop compatible with upper airway obstruction?  
☐ Yes  ☐ No

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

12. Functional impact  
Do the Veteran’s central nervous system disorders impact his or her ability to work?  
☐ Yes  ☐ No  
If yes, describe impact of each of the Veteran’s central nervous system disorder condition(s), providing one or more examples: __________________________________________________________________________________

13. Remarks, if any: __________________________________________________________________________________________________________

Physician signature: ____________________________ Date: __________________________
Physician printed name: ____________________________
Medical license #: ____________________________ Physician address: ____________________________
Phone: ____________________________ Fax: ____________________________

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
6.3. DBQ Ear Conditions (Including Vestibular and Infectious Conditions)

Name of patient/Veteran: _____________________________________SSN: __________________

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

1. Diagnosis

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

☐ Yes  ☐ No

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

☐ Meniere’s syndrome or endolymphatic hydrops  ICD code: ______  Date of diagnosis: ____________

☐ Peripheral vestibular disorder  ICD code: ______  Date of diagnosis: ____________

☐ Benign Paroxysmal Positional Vertigo (BPPV)  ICD code: ______  Date of diagnosis: ____________

☐ Chronic otitis externa  ICD code: ______  Date of diagnosis: ____________

☐ Chronic suppurative otitis media  ICD code: ______  Date of diagnosis: ____________

☐ Chronic nonsuppurative otitis media (serous otitis media)  ICD code: ______  Date of diagnosis: ____________

☐ 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
- Moderate
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. Gallbladder 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:
27

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 cholecintigraphy)  
  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?
☐ 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)

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?
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.
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
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: ____________
☐ Cellic disease  ICD code: ______  Date of diagnosis: ____________
☐ Diverticulitis  ICD code: ______  Date of diagnosis: ____________
☐ Intestinal neoplasm  ICD code: ______  Date of diagnosis: ____________
☐ Peritoneal adhesions attributable to diverticulitis
   If checked, ALSO complete the Peritoneal Adhesions Questionnaire.
   ICD code: ______  Date of diagnosis: ____________

☐ Other non-surgical or non-infectious intestinal conditions:

Other diagnosis #1: ______________
ICD code:  __________________
Date of diagnosis: ______________

Other diagnosis #2: ______________
ICD code:  __________________
Date of diagnosis: ______________

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

2. Medical history
a. Describe the history (including onset and course) of the Veteran’s intestinal condition (brief summary): _______

b. Is continuous medication required for control of the Veteran’s intestinal condition?
☐ Yes  ☐ No

If yes, list only those medications required for the intestinal condition: _________________________
c. Has the Veteran had surgical treatment for an intestinal condition?
   ☐ Yes  ☐ No
   If yes, ALSO complete the Intestinal Surgery Questionnaire.

3. Signs and symptoms
   Does the Veteran have any signs or symptoms attributable to any non-surgical non-infectious intestinal conditions?
   ☐ Yes  ☐ No
   If yes, check all that apply:
   ☐ Diarrhea
       If checked, describe: __________________
   ☐ Alternating diarrhea and constipation
       If checked, describe: __________________
   ☐ Abdominal distension
       If checked, describe: __________________
   ☐ Anemia
       If checked, provide hemoglobin/hematocrit in Diagnostic testing section.
   ☐ Nausea
       If checked, describe: __________________
   ☐ Vomiting
       If checked, describe: __________________
   ☐ Other, describe: ___________________

4. Symptom episodes, attacks and exacerbations
   Does the Veteran have episodes of bowel disturbance with abdominal distress, or exacerbations or attacks of the intestinal condition?
   ☐ Yes  ☐ No
   If yes, indicate severity and frequency: (check all that apply)
   ☐ Episodes of bowel disturbance with abdominal distress
       If checked, indicate frequency:
       ☐ Occasional episodes
       ☐ Frequent episodes
       ☐ More or less constant abdominal distress
   ☐ Episodes of exacerbations and/or attacks of the intestinal condition
       If checked, describe typical exacerbation or attack: __________________
       Indicate number of exacerbations and/or attacks in past 12 months:
       ☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6  ☐ 7 or more

5. Weight loss
   Does the Veteran have weight loss attributable to an intestinal condition (other than surgical or infectious condition)?
   ☐ Yes  ☐ No
   If yes, provide Veteran’s baseline weight: _______ and current weight: _______
   (For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

6. Malnutrition, complications and other general health effects
   Does the Veteran have malnutrition, serious complications or other general health effects attributable to the intestinal condition?
   ☐ Yes  ☐ No
   If yes, indicate findings: (check all that apply)
   ☐ Health only fair during remissions
   ☐ General debility
   ☐ Serious complication such as liver abscess, describe: ______________
   ☐ Malnutrition
       If checked, is malnutrition marked?  ☐ Yes  ☐ No
   ☐ Other, describe: ___________________
Note: Complete additional Disability Questionnaire(s) for complications noted, as deemed appropriate (schedule with appropriate provider)

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

b. Is the neoplasm
   ☐ Benign ☐ Malignant

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

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

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

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

b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
   ☐ Yes ☐ No
   If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?
   ☐ Yes ☐ No
   If yes, also complete a Scars Questionnaire.
9. Diagnostic testing
NOTE: If imaging studies, diagnostic procedures or laboratory testing has been performed and reflects the Veteran’s current condition, provide most recent results; no further studies or testing are required for this examination.

a. Has laboratory testing been performed?
☐ Yes  ☐ No
If yes, check all that apply:
☐ CBC (if anemia due to any intestinal condition is suspected or present)
   Date of test: ___________
   Hemoglobin: ______ Hematocrit: ______ White blood cell count: ______ Platelets: ______
☐ Other, specify: ______ Date of test: ___________
   Results: ______________

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

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

10. Functional impact
Does the Veteran’s intestinal condition impact his or her ability to work?
☐ Yes  ☐ No
If yes, describe the impact of each of the Veteran’s intestinal conditions, providing one or more examples: _____

11. Remarks, if any:
__________________________________________________________

Physician signature: ___________________________ Date: __________________
Physician printed name: ___________________________
Medical license #: _____________ Physician address: ___________________________
Phone: __________________ Fax: ___________________

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
6.11. DBQ Hepatitis, Cirrhosis and other Liver Conditions

Name of patient/Veteran: _____________________________________ SSN:

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

1. Diagnosis

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

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

☐ 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
  - [ ] Indicate frequency and severity: [ ] Intermittent [ ] Daily [ ] Near-constant and debilitating
- [ ] Malaise
  - [ ] Indicate frequency and severity: [ ] Intermittent [ ] Daily [ ] Near-constant and debilitating
- [ ] Anorexia
  - [ ] Indicate frequency and severity: [ ] Intermittent [ ] Daily [ ] Near-constant and debilitating
- [ ] Nausea
  - [ ] Indicate frequency and severity: [ ] Intermittent [ ] Daily [ ] Near-constant and debilitating
- [ ] Vomiting
  - [ ] Indicate frequency and severity: [ ] Intermittent [ ] Daily [ ] Near-constant and debilitating
- [ ] Arthralgia
  - [ ] Indicate frequency and severity: [ ] Intermittent [ ] Daily [ ] Near-constant and debilitating
- [ ] Weight loss
  - [ ] Indicate 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
  - [ ] 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: _______________________________

b. If yes, indicate signs and symptoms attributable to chronic or infectious liver diseases (check all that apply):
- [ ] Fatigue
  - [ ] Indicate frequency and severity: [ ] Intermittent [ ] Daily [ ] Near-constant and debilitating
- [ ] Malaise
  - [ ] Indicate frequency and severity: [ ] Intermittent [ ] Daily [ ] Near-constant and debilitating
- [ ] Anorexia
  - [ ] Indicate frequency and severity: [ ] Intermittent [ ] Daily [ ] Near-constant and debilitating
- [ ] Nausea
  - [ ] Indicate frequency and severity: [ ] Intermittent [ ] Daily [ ] Near-constant and debilitating
- [ ] Vomiting
  - [ ] Indicate frequency and severity: [ ] Intermittent [ ] Daily [ ] Near-constant and debilitating
- [ ] Arthralgia
  - [ ] Indicate frequency and severity: [ ] Intermittent [ ] Daily [ ] Near-constant and debilitating
- [ ] Weight loss
  - [ ] Indicate 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
  - [ ] 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: _______________________________

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)
☐ Hepatitis C genotype
☐ Hepatitis C viral titers
☐ AST
☐ ALT
☐ Alkaline phosphatase
☐ Bilirubin
☐ INR (PT)
☐ Creatinine
☐ MELD score
☐ Other, describe:

Date: ___________ Results: ______________

Date: ___________ Results: ______________

Date: ___________ Results: ______________

Date: ___________ Results: ______________

Date: ___________ Results: ______________

Date: ___________ Results: ______________

Date: ___________ Results: ______________

Date: ___________ Results: ______________

Date: ___________ Results: ______________

Date: ___________ Results: ______________

c. Has a liver biopsy been performed?
Yes ☐ No ☐
Date of test: ___________ Results: ______________

□ 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): ______________

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 hypersonolence
   ___ 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
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nighttime awakening to void 3 to 4 times</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nighttime awakening to void 5 or more times</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Does the Veteran have voiding dysfunction causing obstructed voiding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>attributable to MS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ Yes ___ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, check all signs and symptoms that apply:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hesitancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If checked, is hesitancy marked?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ Yes ___ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slow or weak stream</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If checked, is stream markedly slow or weak?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ Yes ___ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased force of stream</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If checked, is force of stream markedly decreased?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ Yes ___ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stricture disease requiring dilatation 1 to 2 times per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stricture disease requiring periodic dilatation every 2 to 3 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent urinary tract infections secondary to obstruction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uroflowmetry peak flow rate less than 10 cc/sec</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post void residuals greater than 150 cc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary retention requiring intermittent or continuous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>catheterization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Does the Veteran have voiding dysfunction requiring the use of an</td>
<td></td>
<td></td>
</tr>
<tr>
<td>appliance attributable to MS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ Yes ___ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, describe:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Does the Veteran have a history of recurrent symptomatic urinary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>tract infections attributable to MS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ Yes ___ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, check all treatments that apply:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-term drug therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If checked, list medications used for urinary tract infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and indicate dates for courses of treatment over the past 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>months:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If checked, indicate frequency of hospitalization:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ 1 or 2 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ More than 2 per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drainage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If checked, indicate dates when drainage performed over past</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 months:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ Other management/treatment not listed above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of management/treatment including dates of treatment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Does the Veteran (if male) have erectile dysfunction attributable to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ Yes ___ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, is the Veteran able to achieve an erection (without medication)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sufficient for penetration and ejaculation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ Yes ___ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no, is the Veteran able to achieve an erection (with medication)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sufficient for penetration and ejaculation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>__ Yes ___ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I. Visual disturbances
Does the Veteran have any visual disturbances attributable to MS?
___ Yes   ___ No
If yes, check all that apply, and also complete Eye Questionnaire (schedule with appropriate examiner):
___ Diplopia
___ Blurring of vision
___ Internuclear ophthalmoplegia
___ Decreased visual acuity
   If checked, specify: ___ unilateral   ___ bilateral
___ Visual scotoma
   If checked, specify: ___ unilateral   ___ bilateral
___ Nystagmus
___ Optic neuritis
___ Other, describe: ____________________________________________________________

4. Neurologic exam

a. Gait
___ Normal   ___ Abnormal, describe: ____________________________________________
If gait is abnormal, and the Veteran has more than one medical condition contributing to the abnormal gait, identify the conditions and describe each condition’s contribution to the abnormal gait: ______________________________________

b. Strength
Rate strength according to the following scale:
0/5 No muscle movement
1/5 Visible muscle movement, but no joint movement
2/5 No movement against gravity
3/5 No movement against resistance
4/5 Less than normal strength
5/5 Normal strength
___ All Normal
Shoulder extension:
   Right: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
   Left: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
Shoulder flexion:
   Right: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
   Left: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
Elbow flexion:
   Right: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
   Left: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
Elbow extension:
   Right: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
   Left: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
Wrist flexion:
   Right: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
   Left: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
Wrist extension:
   Right: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
   Left: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
Grip:
   Right: ___ 5/5 ___ 4/5 ___ 3/5 ___ 2/5 ___ 1/5 ___ 0/5
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
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
   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):

<table>
<thead>
<tr>
<th>Device</th>
<th>Frequency of use</th>
<th>Occasional</th>
<th>Regular</th>
<th>Constant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheelchair</td>
<td>Frequency of use</td>
<td>Occasional</td>
<td>Regular</td>
<td>Constant</td>
</tr>
<tr>
<td>Brace(s)</td>
<td>Frequency of use</td>
<td>Occasional</td>
<td>Regular</td>
<td>Constant</td>
</tr>
<tr>
<td>Crutch(es)</td>
<td>Frequency of use</td>
<td>Occasional</td>
<td>Regular</td>
<td>Constant</td>
</tr>
<tr>
<td>Cane(s)</td>
<td>Frequency of use</td>
<td>Occasional</td>
<td>Regular</td>
<td>Constant</td>
</tr>
<tr>
<td>Walker</td>
<td>Frequency of use</td>
<td>Occasional</td>
<td>Regular</td>
<td>Constant</td>
</tr>
<tr>
<td>Other:</td>
<td>Frequency of use</td>
<td>Occasional</td>
<td>Regular</td>
<td>Constant</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Test</th>
<th>Date of test</th>
<th>Results</th>
<th>Date of test</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone scan</td>
<td>Date of test</td>
<td>Results</td>
<td>Date of test</td>
<td>Results</td>
</tr>
<tr>
<td>X-ray</td>
<td>Date of test</td>
<td>Results</td>
<td>Date of test</td>
<td>Results</td>
</tr>
<tr>
<td>MRI</td>
<td>Date of test</td>
<td>Results</td>
<td>Date of test</td>
<td>Results</td>
</tr>
<tr>
<td>Complete blood count (CBC)</td>
<td>Date of test</td>
<td>Results</td>
<td>Date of test</td>
<td>Results</td>
</tr>
<tr>
<td>C-reactive protein (CRP)</td>
<td>Date of test</td>
<td>Results</td>
<td>Date of test</td>
<td>Results</td>
</tr>
<tr>
<td>Erythrocyte sedimentation rate (ESR)</td>
<td>Date of test</td>
<td>Results</td>
<td>Date of test</td>
<td>Results</td>
</tr>
<tr>
<td>Blood culture</td>
<td>Date of test</td>
<td>Results</td>
<td>Date of test</td>
<td>Results</td>
</tr>
<tr>
<td>Bone biopsy and culture</td>
<td>Date of test</td>
<td>Results</td>
<td>Date of test</td>
<td>Results</td>
</tr>
</tbody>
</table>
b. Are there any other significant diagnostic test findings and/or results?
☐ Yes  ☐ No
If yes, provide type of test or procedure, date and results (brief summary):

10. Functional impact
Does the Veteran’s osteomyelitis impact his or her ability to work? ☐ Yes  ☐ No
If yes describe the impact of the Veteran’s osteomyelitis or residuals of treatment, providing one or more examples:

11. Remarks, if any:

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

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.
6.15. DBQ Peritoneal Adhesions

Name of patient/Veteran: ____________________________ SSN: ____________

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

1. Diagnosis
Does the Veteran now have or has he/she ever been diagnosed with a peritoneal adhesion?
☐ Yes ☐ No

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

Diagnosis #1: __________________________
ICD code: __________________________
Date of diagnosis #1: _______________

Diagnosis #2: __________________________
ICD code: __________________________
Date of diagnosis #2: _______________

Diagnosis #3: __________________________
ICD code: __________________________
Date of diagnosis #3: _______________

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

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

b. Does the Veteran have a history of operative, traumatic or infectious (intraabdominal) process?
☐ Yes ☐ No

If yes, indicate organ(s) affected (check all that apply):
☐ Stomach ☐ Gall bladder ☐ Liver ☐ Small intestine ☐ Large intestine ☐ other: ____________

c. Has the Veteran had severe peritonitis, ruptured appendix, perforated ulcer or operation with drainage?
☐ Yes ☐ No

d. Does the Veteran have a current diagnosis of peritoneal adhesions?
☐ Yes ☐ No

If yes, indicate organ(s) affected (check all that apply):
☐ Stomach ☐ Gall bladder ☐ Liver ☐ Small intestine ☐ Large intestine ☐ other: ____________

e. Does the Veteran have any signs and/or symptoms due to peritoneal adhesions?
☐ Yes ☐ No

If yes, indicate signs and symptoms: (check all that apply)
☐ Delayed motility of barium meal (on X-ray)
☐ Partial or complete bowel obstruction
☐ Reflex disturbances
☐ Pain
☐ Nausea
Vomiting  
Abdominal distention  
Constipation (perhaps alternating with diarrhea)

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

3. Severity of manifestations of peritoneal adhesions  
Indicate level of severity of signs and/or symptoms, if present: (check all that apply in each level)

a. Level IV  
☐ Severe  
☐ Definite partial obstruction shown by x-ray  
☐ Frequent episodes of severe colic distension  
☐ Frequent episodes of severe nausea  
☐ Frequent episodes of severe vomiting  
☐ Prolonged episodes of severe colic distension  
☐ Prolonged episodes of severe nausea  
☐ Prolonged episodes of severe vomiting

b. Level III  
☐ Moderately severe  
☐ Partial obstruction manifested by delayed motility of barium meal  
☐ Less frequent episodes of pain  
☐ Less prolonged episodes of pain

c. Level II  
☐ Moderate  
☐ Pulling pain on attempting work or aggravated by movements of the body  
☐ Occasional episodes of colic pain  
☐ Occasional episodes of nausea  
☐ Occasional episodes of constipation (perhaps alternating with diarrhea)  
☐ Abdominal 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.
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  [x]
   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  [x]
      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  [x]
   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  [x]
   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  [x]
   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  [x]
   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  [x]
   If yes, describe impact of each of the Veteran’s stomach or duodenum conditions, providing one or more examples:
9. Remarks, if any: ______________________________________________________________

Physician signature: __________________________________________ Date: ______________
Physician printed name: __________________________________________
Medical license #: ________ Physician address: __________________________
Phone: _______________ Fax: __________________________

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

7.1 Software

The VistA software is being distributed as a PackMan patch message through the National Patch Module (NPM). The KIDS build for this patch is DVBA*2.7*174.

7.2 User Documentation

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

download.vista.med.va.gov

This transmits the files from the first available FTP server. Sites may also elect to retrieve software directly from a specific server as follows:

<table>
<thead>
<tr>
<th>OI&amp;T Field Office</th>
<th>FTP Address</th>
<th>Directory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany</td>
<td>ftp.fo-albany.med.va.gov</td>
<td>[anonymous.software]</td>
</tr>
<tr>
<td>Hines</td>
<td>ftp.fo-hines.med.va.gov</td>
<td>[anonymous.software]</td>
</tr>
<tr>
<td>Salt Lake City</td>
<td>ftp.fo-slc.med.va.gov</td>
<td>[anonymous.software]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>File Name</th>
<th>Format</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DVBA_27_P174_RN.PDF</td>
<td>Binary</td>
<td>Release Notes</td>
</tr>
</tbody>
</table>

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://vbacodmint1.vba.va.gov/bl/21/DBQ/default.asp