Compensation and Pension Record Interchange (CAPRI)

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

Release Notes
Patch: DVBA*2.7*175

September 2011

Department of Veterans Affairs
Office of Enterprise Development
Management & Financial Systems

Preface

Purpose of the Release Notes

The Release Notes document describes the new features and functionality of patch DVBA*2.7*175. (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs).

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

Table of Contents

1. Purpose

The purpose of this document is to provide an overview of the enhancements and modifications to functionality specifically designed for Patch DVBA*2.7*175.

Patch DVBA *2.7*175 (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs) introduces enhancements and updates made to the AUTOMATED MED INFO EXCHANGE (AMIE) V 2.7 package and the Compensation & Pension Record Interchange (CAPRI) application in support of the new Compensation and Pension (C&P) Disability Benefits Questionnaires (DBQs).

2. Overview

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

1. **DBQ ABDOMINAL, INGUINAL, AND FEMORAL HERNIAS**
2. **DBQ CHRONIC FATIGUE SYNDROME**
3. **DBQ COLD INJURY RESIDUALS**
4. **DBQ CRANIAL NERVES DISEASES**
5. **DBQ ENDOCRINE DISEASES (OTHER THAN THYROID, PARATHRYOID OR DIABETES MELLITUS)**
6. **DBQ FIBROMYALGIA**
7. **DBQ FORMER PRISONER OF WAR (POW) PORTOCAL**
8. **DBQ GENERAL MEDICAL - COMPENSATION**
9. **DBQ GENERAL MEDICAL – PENSION**
10. **DBQ GULF WAR GENERAL MEDICAL EXAMINATION**
11. **DBQ HIV-RELATED ILLNESSES**
12. **DBQ INFECTIOUS DISEASES (OTHER THAN HIV-RELATED ILLNESS, CHRONIC FATIGUE SYNDROME AND TUBERCULOSIS**
13. **DBQ INITIAL EVALUATION OF RESIDUALS OF TRAUMATIC BRAIN INJURY (I-TBI) DISABILITY**
14. **DBQ LOSS OF SENSE OR SMELL AND OR TASTE**
15. **DBQ NARCOLEPSY**
16. **DBQ NUTRITIONAL DEFICIENCES**
17. **DBQ ORAL AND DENTAL CONDITIONS INCLUDING MOUTH, LIPS AND TONGUE (OTHER THAN TEMPOROMANDIBULAR JOINT CONDITIONS)**
18. **DBQ RESPIRATORY CONDITIONS (OTHER THAN TUBERCULOSIS AND SLEEP ANPEA)**
19. **DBQ REVIEW EVALUATION OF RESIDUALS OF TRAUMATIC BRAIN INJURY (R-TBI)**
20. **DBQ SEIZURE DISORDERS (EPILEPSY)**
21. **DBQ SINUSITIS, RHINITIS AND OTHER CONDITIONS OF THE NOSE, THROAT, LARYNX AND PHARYNX**
22. **DBQ SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) AND OTHER AUTOIMMUNE DISEASES (OTHER THAN HIV AND DIABETES MELLITUS TYPE I)**

23. **DBQ THYROID AND PARATHYROID CONDITIONS**
24. **DBQ URINARY TRACT (INCLUDING BLADDER AND URETHRA) CONDITIONS (EXCLUDING MALE REPRODUCTIVE ORGANS)**

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

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

3. Associated Remedy Tickets & New Service Requests

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

HD0000000517164
DVBA*2.7*174 VistA Patch Installation test problem - Name of veteran did not transfer automatically to Gynecological DBQ

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

4. Defects Fixes

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

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

5. Enhancements

This section provides an overview of the modifications and primary functionality that will be delivered in Patch DVBA*2.7*175.

5.1. CAPRI – DBQ Template Additions

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

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

- **DBQ ABDOMINAL, INGUINAL, AND FEMORAL HERNIAS**
- **DBQ CHRONIC FATIGUE SYNDROME**
- **DBQ COLD INJURY RESIDUALS**
- **DBQ CRANIAL NERVES DISEASES**
- **DBQ ENDOCRINE DISEASES (OTHER THAN THYROID, PARATHRYOID OR DIABETES MELLITUS)**
- **DBQ FIBROMYALGIA**
- **DBQ FORMER PRISONER OF WAR (POW) PORTOCAL**
- **DBQ GENERAL MEDICAL - COMPENSATION**
- **DBQ GENERAL MEDICAL – PENSION**
- **DBQ GULF WAR GENERAL MEDICAL EXAMINATION**
- **DBQ HIV-RELATED ILLNESSES**
- **DBQ INFECTIOUS DISEASES (OTHER THAN HIV-RELATED ILLNESS, CHRONIC FATIGUE SYNDROME AND TUBERCULOSIS**
- **DBQ INITIAL EVALUATION OF RESIDUALS OF TRAUMATIC BRAIN INJURY (I-TBI) DISABILITY**
- **DBQ LOSS OF SENSE OR SMELL AND OR TASTE**
- **DBQ NARCOLEPSY**
- **DBQ NUTRITIONAL DEFICIENCES**
- **DBQ ORAL AND DENTAL CONDITIONS INCLUDING MOUTH, LIPS AND TONGUE (OTHER THAN TEMPOROMANDIBULAR JOINT CONDITIONS)**
- **DBQ RESPIRATORY CONDITIONS (OTHER THAN TUBERCULOSIS AND SLEEP ANPEA)**
- **DBQ REVIEW EVALUATION OF RESIDUALS OF TRAUMATIC BRAIN INJURY (R-TBI)**
- **DBQ SEIZURE DISORDERS (EPILEPSY)**
- **DBQ SINUSITIS, RHINITIS AND OTHER CONDITIONS OF THE NOSE, THROAT, LARYNX AND PHARYNX**
- **DBQ SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) AND OTHER AUTOIMMUNE DISEASES (OTHER THAN HIV AND DIABETES MELLITUS TYPE I)**
- **DBQ THYROID AND PARATHYROID CONDITIONS**
- **DBQ URINARY TRACT (INCLUDING BLADDER AND URETHRA) CONDITIONS (EXCLUDING MALE REPRODUCTIVE ORGANS)**

5.2. AMIE–DBQ Worksheet Additions

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

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

5.2. AMIE–DBQ Worksheet Modifications

VBAVACO has approved modifications for the following AMIE C&P Examination worksheets that are accessible through the VISTA AMIE software package.

- **DBQ AMPUTATIONS**
- **DBQ AMYOTROPHIC LATERAL SCLEROSIS (LOU GEHRIG'S DISEASE)**
- **DBQ ANKLE CONDITIONS**
- **DBQ ARTERY AND VEIN CONDITIONS**
- **DBQ BACK (THORACOLUMBAR SPINE) CONDITIONS**
- **DBQ BREAST CONDITIONS AND DISORDERS**
- **DBQ CENTRAL NERVOUS SYSTEM DISEASES**
- **DBQ DIABETES MELLITUS**
- **DBQ DIABETIC SENSORY-MOTOR PERIPHERAL NEUROPATHY**
- **DBQ EAR CONDITIONS**

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

- **DBQ TEMPOROMANDIBULAR JOINT (TMJ) CONDITIONS**
- **DBQ TUBERCULOSIS**
- **DBQ WRIST CONDITIONS**

5.3. CAPRI Template Defects

5.3.1. DBQ Gynecological Conditions

Issue
When the DBQ GYNECOLOGICAL CONDITIONS is merged with another template the "Veteran's name" isn't included on the report.

Resolution
The Veteran's name will now appear on the report.

5.3.2. DBQ Initial PTSD

Issue
Section 3D contains an incomplete sentence.

Resolution
Section 3D now displays the complete sentence.

5.3.3. DBQ Male Reproductive Systems Conditions

Issue
Remove ICD code and Date of diagnosis from "Other diagnosis" option in Section 1.

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

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

Issue
Section 6-Sensory Exam, when the "Decreased" option is checked for Left in the Upper anterior thigh (L2) area, the data for the Thigh/knee (L3/4) data is not accurately reflected on the report.

Resolution
When "decreased" is chosen for Left Upper anterior thigh (L2), the data entered for Thigh/Knee (L3/4) will be displayed accurately on the report.

Issue
When DBQ Peripheral Nerves Conditions (not including Diabetic Sensory-Motor Peripheral Neuropathy) was merged with DBQ Neck (Cervical Spine) certain fields were being shared between the templates. We were advised by VBA to remove the sharing.

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

has been modified to not share fields between templates.

5.3.5. DBQ Wrist Conditions

Issue
When the LEFT Wrist Palmarflexion number "70" option is checked it appears in the working template, but it does not show up when reviewing or printing the report.

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

6. Disability Benefits Questionnaires (DBQs)

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

6.1. DBQ Abdominal, Inguinal and Femoral Hernias

Name of patient/Veteran: _____ SSN: _____

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

SECTION I. Diagnosis
Does the Veteran now have or has he/she ever had any hernia conditions?
☐ Yes ☐ No

If yes, select the Veteran's condition (check all that apply):
☐ Inguinal hernia ICD code: _____ Date of diagnosis: _____
☐ Femoral hernia ICD code: _____ Date of diagnosis: _____
☐ Ventral hernia ICD code: _____ Date of diagnosis: _____
☐ Other, specify below:

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

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

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

SECTION II. Medical History
a. Describe the history (including onset and course) of the Veteran's hernia conditions (brief summary): ____

b. Does the Veteran's treatment plan include taking continuous medication for the diagnosed condition?
☐ Yes ☐ No
If yes, list only those medications used for the diagnosed condition: _____

SECTION III. Hernia conditions
Specify the Veteran's hernia conditions below and complete appropriate sections.

1. ☐ Inguinal hernia
If checked, complete following section:

a. Has the Veteran had surgery for an inguinal hernia?
☐ Yes ☐ No
If yes, indicate side and date of surgery:
☐ Right: Date of surgery: _____
☐ Left: Date of surgery: _____

b. Inguinal hernia exam (check all that apply)

☐ Inguinal hernia present on exam
If checked, indicate side: ☐ Right ☐ Left
☐ No inguinal hernia detected on exam
If checked, indicate side: ☐ Right ☐ Left
☐ No true hernia protrusion
If checked, indicate side: ☐ Right ☐ Left

If inguinal hernia present, indicate size:
Right side: ☐ Small ☐ Large
Left side: ☐ Small ☐ Large

If inguinal hernia present, indicate ability to be reduced:
Right side: ☐ Readily reducible ☐ Not readily reducible
Left side: ☐ Readily reducible ☐ Not readily reducible

If inguinal hernia present, is there an indication for a supporting belt?
☐ Yes ☐ No
If yes, can hernia be supported by truss or belt?
☐ Yes, well supported by truss or belt
If checked, indicate side well supported: ☐ Right ☐ Left
☐ Not well supported by truss or belt
If checked, indicate side not well supported: ☐ Right ☐ Left

c. Surgical status of inguinal hernia (check all that apply):
☐ No previous surgery but hernia appears operable and remediable
If checked, indicate side: ☐ Right ☐ Left
☐ Irremediable, provide reason: _____
If checked, indicate side: ☐ Right ☐ Left
☐ Inoperable, provide reason: _____
If checked, indicate side: ☐ Right ☐ Left
☐ Recurrent hernia following surgical repair
If checked, indicate status of postoperative recurrent hernia:
☐ Recurrent hernia appears operable and remediable
If checked, indicate side: ☐ Right ☐ Left
☐ Irremediable, provide reason: _____
If checked, indicate side: ☐ Right ☐ Left
☐ Inoperable, provide reason: _____
If checked, indicate side: ☐ Right ☐ Left

2. ☐ Femoral hernia
If checked, complete following section:

a. Has the Veteran had surgery for a femoral hernia?
☐ Yes ☐ No
If yes, indicate side and date of surgery:
☐ Right: Date of surgery: _____
☐ Left: Date of surgery: _____

b. Femoral hernia exam (check all that apply)
☐ Femoral hernia present on exam
If checked, indicate side: ☐ Right ☐ Left
☐ No femoral hernia detected on exam
If checked, indicate side: ☐ Right ☐ Left
☐ No true hernia protrusion
If checked, indicate side: ☐ Right ☐ Left

If femoral hernia present, indicate size:
Right side: ☐ Small ☐ Large
Left side: ☐ Small ☐ Large

If femoral hernia present, indicate ability to be reduced:
Right side: ☐ Readily reducible ☐ Not readily reducible
Left side: ☐ Readily reducible ☐ Not readily reducible

If femoral hernia present, is there an indication for a supporting belt?
☐ Yes ☐ No
If yes, can hernia be supported by truss or belt?
☐ Yes, well supported by truss or belt
If checked, indicate side well supported: ☐ Right ☐ Left
☐ Not well supported by truss or belt
If checked, indicate side not well supported: ☐ Right ☐ Left

c. Surgical status of femoral hernia (check all that apply):
☐ No previous surgery but hernia appears operable and remediable
If checked, indicate side: ☐ Right ☐ Left
☐ Irremediable, provide reason: _____
If checked, indicate side: ☐ Right ☐ Left
☐ Inoperable, provide reason: _____
If checked, indicate side: ☐ Right ☐ Left
☐ Recurrent hernia following surgical repair
If checked, indicate status of postoperative recurrent hernia:
☐ Recurrent hernia appears operable and remediable
If checked, indicate side: ☐ Right ☐ Left
☐ Irremediable, provide reason: _____
If checked, indicate side: ☐ Right ☐ Left
☐ Inoperable, provide reason: _____
If checked, indicate side: ☐ Right ☐ Left

3. ☐ Ventral hernia
If checked, complete following section:

a. Has the Veteran had surgery for a ventral hernia?
☐ Yes ☐ No
If yes, provide date of surgery: _____

b. Ventral hernia exam (check all that apply):
☐ Ventral hernia present on exam
☐ No ventral hernia detected on exam

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

☐ Small
☐ Large
☐ Massive
☐ Persistent
☐ Healed ventral hernia or postoperative wounds with weakening of abdominal wall and indication for a supporting belt
☐ Severe diastasis of recti muscles
☐ Extensive diffuse destruction or weakening of muscular and fascial support of abdominal wall
☐ Other, describe: _____

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

☐ Yes ☐ No
If yes, is it able to be supported by truss or belt?
☐ Yes, well supported by truss or belt
☐ Not well supported by truss or belt

c. Surgical status of ventral hernia (check all that apply):
☐ No previous surgery but hernia appears operable and remediable
☐ Irremediable, provide reason: _____
☐ Inoperable, provide reason: _____
☐ Recurrent hernia following surgical repair
If checked, indicate status of postoperative recurrent hernia:
☐ Recurrent hernia appears operable and remediable
☐ Irremediable, provide reason: _____
☐ Inoperable, provide reason: _____

SECTION IV:

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

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

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

2. Diagnostic testing

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

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

3. Functional impact

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

☐ Yes ☐ No
If yes, describe the impact of each of the Veteran's hernia conditions, providing one or more examples: _____

4. Remarks, if any: _____

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

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

6.2. DBQ Chronic Fatigue Syndrome

Name of patient/Veteran: _____SSN: _____

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

1. Diagnosis

Does the Veteran now have or has/she ever been diagnosed with chronic fatigue syndrome?
☐ Yes ☐ No

If yes, select the Veteran's condition (check all that apply):
☐ Chronic fatigue syndrome ICD code: _____ Date of diagnosis: _____
☐ Other, specify:

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

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

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

NOTE: For VA purposes, the diagnosis of chronic fatigue syndrome requires:
a. New onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the usual level for at least 6 months; and
b. The exclusion, by history, physical examination, and laboratory tests, of all other clinical conditions that may produce similar symptoms; and
c. Six or more of the following: acute onset of the condition, low grade fever, non-exudative pharyngitis, palpable or tender cervical or axillary lymph nodes, generalized muscle aches or weakness, fatigue lasting 24 hours or longer after exercise, headaches (of a type, severity or pattern that is different from headaches in the pre-morbid state), migratory joint pains, neuropsychological symptoms, sleep disturbance.

2. Medical History

a. Describe the history (including onset and course) of the Veteran's chronic fatigue syndrome: _____

b. Is continuous medication required for control of chronic fatigue syndrome?
☐ Yes ☐ No
If yes, list only those medications required for the Veteran's chronic fatigue syndrome: _____

c. Are the Veteran's symptoms controlled by continuous medication?
☐ Yes ☐ No

d. Have other clinical conditions that may produce similar symptoms been excluded by history, physical examination and/or laboratory tests to the extent possible?
☐ Yes ☐ No

e. Did the Veteran have an acute onset of chronic fatigue syndrome?
☐ Yes ☐ No

f. Has debilitating fatigue reduced daily activity level to less than 50% of pre-illness level?
☐ Yes ☐ No
If yes, specify length of time daily activity level has been reduced to less than 50% of pre-illness level:
☐ Less than 6 months ☐ 6 months or longer

3. Findings, signs and symptoms

a. Does the Veteran now have or has the Veteran had any findings, signs and symptoms attributable to chronic fatigue syndrome?
☐ Yes ☐ No
If yes, check all that apply:
☐ Debilitating fatigue
☐ Low grade fever
If checked, describe: _____
☐ Nonexudative pharyngitis
If checked, describe: _____
☐ Palpable or tender cervical or axillary lymph nodes
If checked, describe: _____
☐ Generalized muscle aches or weakness
If checked, describe: _____
☐ Fatigue lasting 24 hours or longer after exercise
☐ Headaches (of a type, severity or pattern that is different from headaches in the pre-morbid state)
If checked, describe: _____
☐ Migratory joint pains
If checked, describe: _____
☐ Neuropsychological symptoms
If checked, describe: _____
☐ Sleep disturbance
If checked, describe: _____
☐ Other, describe: _____

b. Does the Veteran now have or has the Veteran had any cognitive impairment attributable to chronic fatigue syndrome?
☐ Yes ☐ No
If yes, check all that apply:
☐ Poor attention
If checked, describe: _____
☐ Inability to concentrate
If checked, describe: _____
☐ Forgetfulness
If checked, describe: _____
☐ Confusion
If checked, describe: _____
☐ Other cognitive impairments, describe: _____

c. Specify frequency of symptoms:
☐ Symptoms wax and wane
☐ Symptoms are nearly constant
☐ Other, describe: _____

d. Do the Veteran's symptoms due to chronic fatigue syndrome result in periods of incapacitation?
NOTE: For VA purposes, chronic fatigue syndrome is considered incapacitating only while it requires bed rest and treatment by a physician.
☐ Yes ☐ No
If yes, indicate total duration of periods of incapacitation over the past 12 months:
- ☐ Less than 1 week
- ☐ At least 1 but less than 2 weeks
- ☐ At least 2 but less than 4 weeks
- ☐ At least 4 but less than 6 weeks
- ☐ At least 6 weeks total duration per year
- ☐ Other, describe: _____

e. Do the Veteran's symptoms due to chronic fatigue syndrome restrict routine daily activities as compared to the pre-illness level?
☐ Yes ☐ No
If yes, specify % of restriction (check all that apply):
- ☐ Symptoms restrict routine daily activities by less than 25% of the pre-illness level (more than 75% of the pre-illness level of activities are not restricted)
- ☐ Symptoms restrict routine daily activities to 50% to 75% of the pre-illness level
- ☐ Symptoms restrict routine daily activities to less than 50% of the pre-illness level
- ☐ Symptoms are so severe as to restrict routine daily activities almost completely
- ☐ Symptoms are so severe as to occasionally preclude self-care
  If checked, described frequency with which this occurs: _____
- ☐ Other, describe: _____

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

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

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

5. Diagnostic testing

NOTE: If diagnostic test results are in the medical record and reflect the Veteran's current chronic fatigue syndrome, repeat testing is not required.

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

6. Functional impact

Does the Veteran's chronic fatigue syndrome impact his or her ability to work?
☐ Yes ☐ No
If yes, describe the impact of the Veteran's chronic fatigue syndrome, providing one or more examples: ___

7. Remarks, if any: _____

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

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

6.3. DBQ Cold Injury Residuals

Name of patient/Veteran: _____ SSN:_____

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

1. Diagnosis:

Does the Veteran now have or has he/she ever been diagnosed with any cold injury(ies)?

☐ Yes ☐ No

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

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

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

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

If there are additional diagnoses that pertain to the cold injury, list using above format:

_____

2. Medical History:

a. Describe the history (including circumstances of onset, body parts affected, signs and symptoms at time of cold injury, treatment initially and currently, including non-medical measures such as moving to a warmer climate, wearing extra socks, etc., and course) of the Veteran's cold injury (brief summary):

_____

b. Dominant Hand:

☐ Right ☐ Left ☐ Ambidextrous

3. Signs and symptoms

Check all that apply:

☐ Right hand

- ☐ Arthralgia or other pain
- ☐ Cold sensitivity
- ☐ Nail abnormalities
- ☐ Locally impaired sensation
- ☐ Numbness
- ☐ Tissue loss
- ☐ Color changes
- ☐ Hyperhidrosis

X-ray abnormalities

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Subarticular punched out lesions

☐ Left hand

- ☐ Arthralgia or other pain
- ☐ Numbness

☐ Cold sensitivity
☐ Nail abnormalities
☐ Locally impaired sensation
☐ Tissue loss
☐ Color changes
☐ Hyperhidrosis

X-ray abnormalities
☐ Osteoarthritis
☐ Osteoporosis
☐ Subarticular punched out lesions

☐ Right foot
☐ Arthralgia or other pain
☐ Cold sensitivity
☐ Nail abnormalities
☐ Locally impaired sensation
☐ Numbness
☐ Tissue loss
☐ Color changes
☐ Hyperhidrosis

X-ray abnormalities
☐ Osteoarthritis
☐ Osteoporosis
☐ Subarticular punched out lesions

☐ Left foot
☐ Arthralgia or other pain
☐ Cold sensitivity
☐ Nail abnormalities
☐ Locally impaired sensation
☐ Numbness
☐ Tissue loss
☐ Color changes
☐ Hyperhidrosis

X-ray abnormalities
☐ Osteoarthritis
☐ Osteoporosis
☐ Subarticular punched out lesions

☐ Right ear
☐ Pain ☐ Numbness
☐ Cold sensitivity
☐ Color changes
☐ Hyperhidrosis
☐ Tissue loss
☐ Locally impaired sensation

☐ Left ear
☐ Pain ☐ Numbness
☐ Cold sensitivity
☐ Color changes
☐ Hyperhidrosis
☐ Tissue loss
☐ Locally impaired sensation

☐ Nose
☐ Pain ☐ Numbness
☐ Cold sensitivity
☐ Color changes
☐ Hyperhidrosis
☐ Tissue loss
☐ Locally impaired sensation

☐ Other (specify: _____)

☐ Arthralgia or other pain
☐ Cold sensitivity
☐ Nail abnormalities
☐ Locally impaired sensation
☐ Numbness
☐ Tissue loss
☐ Color changes
☐ Hyperhidrosis

X-ray abnormalities
☐ Osteoarthritis
☐ Osteoporosis
☐ Subarticular punched out lesions

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

NOTE: If there are amputations of fingers or toes, or complications such as squamous cell carcinoma at the site of a cold injury scar, or peripheral neuropathy, and other disabilities that may be the residual effects of cold injury, such as Raynaud's phenomenon, muscle atrophy, etc., also complete appropriate Questionnaire(s).

4. Diagnostic testing

The diagnoses of osteoporosis, subarticular punched out lesions, or osteoarthritis must be confirmed by X-rays. Once these abnormalities have been documented, no further imaging studies are indicated.

Are there X-rays of the affected areas?
☐ Yes ☐ No
If yes, provide the date of the most recent x-rays for each affected body part:
_____
If no, arrange for X-rays to be taken.

5. Assistive devices

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

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

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

6. Remaining effective function of the extremities

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

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire

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

☐ Yes ☐ No

If yes, describe (brief summary): _____

8. Functional impact

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

☐ Yes ☐ No

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

_____

9. Remarks, if any: _____

Physician signature: _____ Date: _____

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

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

6.4. DBQ Cranial Nerves Diseases

Name of patient/Veteran: _____ SSN: _____

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

1. Diagnosis

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

If yes, provide only diagnoses that pertain to cranial nerve conditions:
Diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____

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

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

If there are additional diagnoses that pertain to cranial nerves, list using above format: _____

DEFINITIONS: For VA purposes, neuralgia indicates a condition characterized by a dull and intermittent pain of typical distribution so as to identify the nerve, while neuritis is characterized by loss of reflexes, muscle atrophy, sensory disturbances and constant pain, at times excruciating.

NOTE: Disabilities from lesions of peripheral portions of first, second, third, fourth, sixth, and eigth nerve s are addressed in other DBQs.

2. Medical History

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

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

☐ Cranial nerve I (olfactory)
If checked, complete the Loss of Sense of Smell and Taste DBQ in lieu of this Questionnaire.
☐ Cranial nerves II-IV
If checked, complete Eye DBQ
☐ Cranial nerve V (trigeminal)
☐ Cranial nerve VII (facial)
☐ Cranial nerve IX (glossopharyngeal)
☐ Cranial nerve X (vagus)
☐ Cranial nerve XI (spinal accessory)
☐ Cranial nerve XII (hypoglossal)

3. Symptoms

Does the Veteran have symptoms attributable to any cranial nerve conditions affecting cranial nerves V-XII?
☐ Yes ☐ No
If yes, indicate symptoms (check all that apply):

☐ Constant pain, at times excruciating
If checked, indicate location and severity:
Upper face, eye and/or forehead
Right ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
Mid face
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
Lower face
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
Side of mouth and throat
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe

☐ Intermittent pain
If checked, indicate location and severity:
Upper face, eye and/or forehead
Right ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
Mid face
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe

Lower face
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
Side of mouth and throat
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe

☐ Dull pain
If checked, indicate location and severity:
Upper face, eye and/or forehead
Right ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
Mid face
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
Lower face
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
Side of mouth and throat
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe

☐Paresthesias and/or dysesthesias
If checked, indicate location and severity:
Upper face, eye and/or forehead
Right ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
Mid face
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
Lower face
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe

Side of mouth and throat
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
☐ Numbness
If checked, indicate location and severity:
Upper face, eye and/or forehead
Right ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
Mid face
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
Lower face
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
Side of mouth and throat
Right: ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Mild ☐ Moderate ☐ Severe
☐ Difficulty chewing
If checked, indicate severity:
☐ Mild ☐ Moderate ☐ Severe
☐ Difficulty swallowing
If checked, indicate severity:
☐ Mild ☐ Moderate ☐ Severe
☐ Difficulty speaking
If checked, indicate severity:
☐ Mild ☐ Moderate ☐ Severe
☐ Increased salivation
If checked, severity:
☐ Mild ☐ Moderate ☐ Severe
☐ Decreased salivation
If checked, severity:
☐ Mild ☐ Moderate ☐ Severe
☐ Gastrointestinal symptoms
If checked, severity:
☐ Mild ☐ Moderate ☐ Severe
If checked, describe:_____
☐ Other symptoms
If checked, describe: _____

4. Muscle strength testing

Rate strength using the following levels to estimate strength of muscle groups. This summary provides useful information for VA purposes.

☐ All normal

Cranial nerve V: (Motor: muscles of mastication; clench jaw, palpate masseter, temporalis)
Right: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis
Left: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

Cranial nerve VII, upper portion of face: (Motor: muscles of facial expression; shuts eyes tightly)
Right: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis
Left: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

Cranial nerve VII, lower portion of face: (Motor: muscles of facial expression; grins)
Right: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis
Left: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

Cranial nerve IX, X: (Motor: swallow, cough, palate elevation; “say ah”, gag reflex if indicated)
Right: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis
Left: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

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

Right: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis
Left: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

Cranial nerve XII: (Motor: protrude tongue, move tongue from side to side)
Right: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis
Left: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Complete paralysis

5. Sensory exam

Provide results for sensation testing to light touch for facial sensation:
☐ All normal

Cranial nerve V:

Upper face and forehead
Right: ☐ Normal ☐ Decreased ☐ Absent
Left: ☐ Normal ☐ Decreased ☐ Absent

Mid face:
Right: ☐ Normal ☐ Decreased ☐ Absent
Left: ☐ Normal ☐ Decreased ☐ Absent

Lower face:
Right: ☐ Normal ☐ Decreased ☐ Absent
Left: ☐ Normal ☐ Decreased ☐ Absent

6. Cranial nerve summary evaluation

a. For the following cranial nerves, indicate the cranial nerves affected and severity ("degree of paralysis"), basing the responses on symptoms and findings from the above exam. This section provides an estimation of the severity of the Veteran's cranial nerve condition, which is useful for VA purposes.

NOTE: For VA purposes, the term "incomplete paralysis" indicates a degree of lost or impaired function substantially less than complete paralysis, whether due to varied level of the nerve lesion or to partial regeneration.

☐ Cranial nerve V (trigeminal)
Right: ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete
Left: ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete

☐ Cranial nerve VII (facial):
Right : ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete
Left: ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete

☐ Cranial nerve IX (glossopharyngeal):
Right: ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete
Left: ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete

☐ Cranial nerve X (vagus):
Right: ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete
Left: ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete

☐ Cranial nerve XI (spinal accessory):
Right: ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete
Left: ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete

☐ Cranial nerve XII (hypoglossal):
Right: ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete
Left: ☐ Not affected ☐ Incomplete, moderate ☐ Incomplete, severe ☐ Complete

b. Does the Veteran have any other significant signs or symptoms of a cranial nerve condition, such as impaired salivation or lacrimation due to cranial nerve VII condition?
☐ Yes ☐ No
If yes, describe: _____

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

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

☐ Yes ☐ No

If yes, describe (brief summary): _____

8. Diagnostic testing

For the purpose of this examination, diagnostic or imaging studies are usually not required to diagnose specific cranial nerve conditions in the appropriate clinical setting.

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

☐ Yes ☐ No

If yes, provide type of study, date and results: _____

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

☐ Yes ☐ No

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

9. Functional impact

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

☐ Yes ☐ No

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

_____

10. Remarks, if any: _____

Physician signature: _____ Date: _____

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

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

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

Name of patient/Veteran: _____SSN: _____

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

1. Diagnosis

Does the Veteran have or has he/she ever had an endocrine condition?
☐ Yes ☐ No

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

☐ Cushing's syndrome	ICD code: _____	Date of diagnosis: _____
☐ Acromegaly	ICD code: _____	Date of diagnosis: _____
☐ Diabetes insipidus	ICD code: _____	Date of diagnosis: _____
☐ Addison's disease	ICD code: _____	Date of diagnosis: _____
☐ Pluriglandular syndrome	ICD code: _____	Date of diagnosis: _____
☐ Hyperpituitarism	ICD code: _____	Date of diagnosis: _____
☐ Hyperaldosteronism	ICD code: _____	Date of diagnosis: _____
☐ Pheochromocytoma	ICD code: _____	Date of diagnosis: _____
☐ Other, specify:		

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

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

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

NOTE: If there are any cardiovascular, psychiatric, vision, skin or skeletal complications attributable to an endocrine condition, ALSO complete appropriate Questionnaires if indicated.

2. Medical history

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

b. Is continuous medication required for control of an endocrine condition?
☐ Yes ☐ No
If yes, specify the condition and list only those medications required for the Veteran's endocrine condition: _____

c. Has the Veteran had surgery for an endocrine condition?
☐ Yes ☐ No
If yes, specify the condition and type of surgery: _____
Date of surgery: _____

d. Has the Veteran had any other type of treatment for an endocrine condition?
☐ Yes ☐ No

If yes, specify the condition and type of treatment: _____
Date of treatment: _____

3. Cushing's syndrome

Does the Veteran have any findings, signs or symptoms attributable to Cushing's syndrome?
☐ Yes ☐ No
If yes, check all that apply:
- ☐ Striae
- ☐ Obesity
- ☐ Moon face
- ☐ Glucose intolerance
- ☐ Vascular fragility
- ☐ Loss of muscle strength
- ☐ Enlargement of pituitary or adrenal gland
- ☐ As active, progressive disease including loss of muscle strength
- ☐ Osteoporosis
- ☐ Hypertension
- ☐ Weakness

For all checked conditions or for any other conditions, describe: _____

4. Acromegaly

Does the Veteran currently have any findings, signs or symptoms attributable to acromegaly?
☐ Yes ☐ No
If yes, check all that apply:
- ☐ Enlargement of acral parts
- ☐ Overgrowth of long bones
- ☐ Enlarged sella turcica
- ☐ Arthropathy
- ☐ Glucose intolerance
- ☐ Hypertension
  If checked, provide BPx3: _____
- ☐ Evidence of increased intracranial pressure (such as visual field defect)
- ☐ Cardiomegaly

For all checked conditions or for any other conditions, describe: _____

5. Diabetes insipidus

Does the Veteran currently have any findings, signs or symptoms attributable to diabetes insipidus?
☐ Yes ☐ No
If yes, check all that apply:
- ☐ Polyuria
- ☐ Near-continuous thirst
- ☐ Episodes of dehydration NOT requiring parenteral hydration in past 12 months
  If checked, indicate frequency of documented episodes in past 12 months:
  ☐ 0 ☐ 1 ☐ 2 ☐ More than 2
- ☐ Episodes of dehydration requiring parenteral hydration in past 12 months
  If checked, indicate frequency of documented episodes in past 12 months:
  ☐ 0 ☐ 1 ☐ 2 ☐ More than 2
- ☐ Other, describe: _____

6. Addison's disease (adrenal cortical hypofunction)

Does the Veteran currently have any findings, signs or symptoms attributable to Addison's disease?
☐ Yes ☐ No
If yes, check all that apply:

☐ Corticosteroid therapy required for control
☐ Weakness
☐ Fatigability
☐ Addisonian crisis (acute adrenal insufficiency)
If checked, indicate frequency of Addisonian crises in past 12 months:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than 5
☐ Addisonian "episodes"
If checked, indicate frequency of Addisonian "episodes" in past 12 months:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than 5

For all checked conditions or for any other conditions, describe: _____

NOTE: An Addisonian crisis consists of the rapid onset of peripheral vascular collapse (with acute hypotension and shock), with findings that may include anorexia; nausea; vomiting; dehydration; profound weakness; pain in the abdomen; legs and back; fever, apathy and depressed mentation with possible progression to coma, renal shutdown and death.

For VA purposes, an Addisonian "episode" is a less acute and less severe event than an Addisonian crisis and may consist of anorexia, nausea, vomiting, diarrhea, dehydration, weakness, malaise, orthostatic hypotension or hypoglycemia, but no peripheral vascular collapse.

7. Other endocrine conditions

Does the Veteran have any other endocrine conditions?
☐ Yes ☐ No
If yes, specify condition and describe any current findings, signs and symptoms:
_____

8. Tumors and neoplasms

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

a. Is the neoplasm:
☐ Benign ☐ Malignant

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

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

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

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

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

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

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

10. Diagnostic testing

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

a. Have imaging studies been performed?
☐ Yes ☐ No
If yes, check all that apply:

☐ Magnetic resonance imaging (MRI)	Date: _____	Results: _____
☐ Computed tomography (CT)	Date: _____	Results: _____
☐ Other: _____	Date: _____	Results: _____

b. Has laboratory testing been performed?
☐ Yes ☐ No
If yes, indicate type of test, date and results:
Type of test: _____ Date: _____ Results: _____

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

11. Functional impact

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

12. Remarks, if any: _____

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

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

6.6. DBQ Fibromyalgia

Name of patient/Veteran: _____ SSN: _____

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

1. Diagnosis

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

If yes, select the Veteran's condition (check all that apply):
☐ Fibromyalgia ICD code: _____ Date of diagnosis: _____
☐ Other, specify:

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

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

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

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

2. Medical history

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

b. Is the Veteran currently undergoing treatment for this condition?
☐ Yes ☐ No
If yes, describe: _____

c. Is continuous medication required for control of fibromyagia symptoms?
☐ Yes ☐ No
If yes, list only those continuous medications required for the Veteran's fibromyalgia condition:
_____

d. Are the Veteran's fibromyalgia symptoms refractory to therapy?
☐ Yes ☐ No
If yes, describe: _____

3. Findings, signs and symptoms

a. Does the Veteran currently have any findings, signs or symptoms attributable to fibromyalgia?
☐ Yes ☐ No
If yes, check all that apply:
☐ Widespread musculoskeletal pain
(For VA purposes widespread pain in fibromyalgia means pain in both the left and right sides of the body, that is both above and below the waist, and that affects both the axial skeleton (i.e., cervical spine, anterior chest, thoracic spine or low back) and the extremities.)
☐ Stiffness

If checked, describe: _____

☐ Muscle weakness
If checked, describe: _____
☐ Fatigue
If checked, describe: _____
☐ Sleep disturbances
If checked, describe: _____
☐ Paresthesias
If checked, describe: _____
☐ Headache
If checked, describe: _____
☐ Depression
If checked, describe: _____
If checked, a Mental Disorders Questionnaire must ALSO be completed.
☐ Anxiety
If checked, describe: _____
☐ Irritable bowel symptoms
If checked, describe: _____
☐ Raynaud's-like symptoms
If checked, describe: _____
☐ Other, describe: _____

b. Indicate frequency of fibromyalgia symptoms (check all that apply):
☐ No symptoms
☐ Episodic with exacerbations
☐ Present more than one-third of the time
☐ Constant or nearly constant
☐ Often precipitated by environmental or emotional stress or overexertion
If checked, describe: _____
☐ Other, describe: _____

c. Does the Veteran have tender points for pain?
☐ Yes ☐ No
If yes, check all that apply:
☐ Low cervical region: at anterior aspect of the interspaces between transverse processes of C5-C7
If checked, indicate side: ☐ Right ☐ Left ☐ Both
☐ Second rib: at second costochondral junction
If checked, indicate side: ☐ Right ☐ Left ☐ Both
☐ Occiput: at suboccipital muscle insertion
If checked, indicate side: ☐ Right ☐ Left ☐ Both
☐ Trapezius muscle: midpoint of upper border
If checked, indicate side: ☐ Right ☐ Left ☐ Both
☐ Supraspinatus muscle: above medial border of the scapular spine
If checked, indicate side: ☐ Right ☐ Left ☐ Both
☐ Lateral epicondyle: 2 cm distal to lateral epicondyle
If checked, indicate side: ☐ Right ☐ Left ☐ Both
☐ Gluteal: at upper outer quadrant of buttocks
If checked, indicate side: ☐ Right ☐ Left ☐ Both
☐ Greater trochanter: posterior to greater trochanteric prominence
If checked, indicate side: ☐ Right ☐ Left ☐ Both
☐ Knee: medial joint line
If checked, indicate side: ☐ Right ☐ Left ☐ Both
☐ Other, specify: _____
If checked, indicate side: ☐ Right ☐ Left ☐ Both

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

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

☐ Yes ☐ No

If yes, describe (brief summary): _____

5. Diagnostic testing

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

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

☐ Yes ☐ No

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

6. Functional impact

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

☐ Yes ☐ No

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

7. Remarks, if any: _____

Physician signature: _____ Date: _____

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

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

6.7. DBQ Former Prisoner Of War (POW) Protocol

Name of patient/Veteran: _____SSN: _____

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

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with one or more of the conditions listed below?
☐ Yes ☐ No

If yes, check all that apply:

- ☐ **Atherosclerotic heart disease or hypertensive vascular disease** (including hypertensive heart disease) and their complications (including myocardial infarction, congestive heart failure, arrhythmia) – (Relevant Questionnaires: IHD; Heart Disease)
- ☐ **Avitaminosis** -- (Relevant Questionnaire: Nutritional Deficiencies)
- ☐ **Beriberi** (including beriberi heart disease) -- (Relevant Questionnaires: Nutritional Deficiencies; Heart Disease, if indicated)
  - ☐ **Chronic dysentery** -- (Relevant Questionnaire: appropriate Intestines questionnaire)
- ☐ **Cirrhosis of the liver** -- (Relevant Questionnaire: Hepatitis, Cirrhosis and other Liver Conditions)
- ☐ **Dysthymic disorder** (Depressive neurosis) -- (Relevant Questionnaire: Mental Disorder)
- ☐ **Helminthiasis** -- (Relevant Questionnaires: Nutritional Deficiencies; Infectious Diseases; Hematological and Lymphatic)
- ☐ **Irritable bowel syndrome** -- (Relevant Questionnaire: Intestines (other than surgical or infectious)
- ☐ **Malnutrition and/or other nutritional deficiency** (including optic atrophy associated with malnutrition) -- (Relevant Questionnaires: Nutritional Deficiencies; Eye, if indicated)
- ☐ **Organic residuals of frostbite** (if it is determined that the Veteran was interned in climatic conditions consistent with the occurrence of frostbite) -- (Relevant Questionnaire: Cold Injury Residuals)
- ☐ **Osteoporosis** -- (Relevant Questionnaires: select appropriate Spine or joint questionnaire)
- ☐ **Pellagra** -- (Relevant Questionnaire: Nutritional Deficiencies)
- ☐ **Peptic ulcer disease** -- (Relevant Questionnaire: Stomach and Duodenal Conditions)
- ☐ **Peripheral neuropathy** (except where directly related to infectious causes) -- (Relevant Questionnaire: Peripheral Nerves)
- ☐ **Post-traumatic osteoarthritis** -- (Relevant Questionnaires: select appropriate spine or joint questionnaire)
- ☐ **Psychosis** and/or any of the **anxiety states** -- (Relevant Questionnaires: Initial Post-Traumatic Stress Disorder; Mental Disorder)
- ☐ **Stroke** and its complications -- (Relevant Questionnaires: Central Nervous System & Neuromuscular Diseases; Cranial Nerves)

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

2. Medical history

Perform a thorough review of all body systems. Based on this review, complete the sections below that pertain to the Veteran's symptoms. Complete the appropriate Questionnaire(s) based on your selections below.

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

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

- ☐ Skin Diseases
- ☐ Scars

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

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

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

☐ Hairy Cell & Other B-Cell Leukemias

iii. Is there an eye condition? ☐ Yes ☐ No

If yes, complete the Eyes Questionnaire.

Note: Vision evaluations must be conducted by a specialist.

iv. Is there an ear condition? ☐ Yes ☐ No

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

☐ Hearing Loss and Tinnitus

☐ Ear Conditions

Note: Audio evaluations must be conducted by a specialist.

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

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

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

☐ Loss of Sense of Smell and/or Taste

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

☐ Temporomandibular Joint

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

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

☐ Respiratory Conditions (other than tuberculosis and sleep apnea)

☐ Sleep Apnea

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

If yes, complete the Disorders of the Breast Questionnaire.

viii. Is there a cardiovascular condition? ☐ Yes ☐ No

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

☐ Ischemic Heart Disease

☐ Artery & Vein Conditions (vascular diseases including varicose veins)

☐ Hypertension

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

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

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

☐ Esophageal Disorders (GERD and Hiatal Hernia)

☐ Gallbladder and Pancreas

☐ Infectious Intestinal Conditions

☐ Intestinal Surgery

☐ Intestinal Conditions (other than Surgical and Infectious)

☐ Hepatitis, Cirrhosis, and Other Liver Conditions

☐ Peritoneal Adhesions

☐ Stomach and Duodenal Conditions

☐ Abdominal, Inguinal, and Femoral Hernias

☐ Rectum and Anus (Including Hemorrhoids)

x. Is there a male genitourinary condition? ☐ Yes ☐ No

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

☐ Kidney Conditions

☐ Male Reproductive Organs

☐ Prostate Cancer

☐ Urinary Tract (including Bladder and Urethral) Conditions

xi. Is there a female genitourinary condition? ☐ Yes ☐ No

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

☐ Gynecological Conditions
☐ Kidney Conditions
☐ Urinary Tract (including Bladder and Urethral) Conditions

xii. Is there a musculoskeletal condition? ☐ Yes ☐ No

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

Spine

☐ Back (Thoracolumbar Spine) Conditions
☐ Neck (Cervical Spine) Conditions

Upper Extremities

☐ Hands and Fingers
☐ Wrist
☐ Elbow and Forearm
☐ Shoulder and Arm

Lower Extremities

☐ Flatfeet
☐ Foot (other than Flatfeet)
☐ Ankle
☐ Knee and Lower Leg
☐ Hip and Thigh

Miscellaneous

☐ Amputations
☐ Fibromyalgia
☐ Osteomyelitis
☐ Muscle Injuries
☐ Non-degenerative Arthritis (including inflammatory, autoimmune, crystalline and infectious arthritis) and Dysbaric Osteonecrosis

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

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

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

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

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

xiv. Is there a neurological condition? ☐ Yes ☐ No

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

☐ Parkinson's Disease
☐ Amyotrophic Lateral Sclerosis (ALS)
☐ Cranial Nerves Diseases
☐ Diabetic Sensory-Motor Peripheral Neuropathy
☐ Disease of the Central Nervous System
☐ Fibromyalgia
☐ Narcolepsy
☐ Headaches (including Migraine Headaches)
☐ Multiple Sclerosis (MS)
☐ Peripheral Nerves
☐ Seizure Disorders (Epilepsy)
☐ Initial Evaluation of Residuals of Traumatic Brain Injury (I-TBI)

(The I-TBI Questionnaire can only be completed by a VHA specialist)
☐ Review Evaluation of Residuals of Traumatic Brain Injury (R-TBI)

xv. Is there a psychiatric condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Eating Disorders
☐ Initial PTSD (Initial PTSD Questionnaire can only be completed by VHA specialist)
☐ Mental Disorders (Other Than PTSD)
☐ Review PTSD
Note: Mental evaluations must be conducted by a specialist.

xvi. Is there an infectious disease, an immune disorder and/or nutritional deficiency? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Chronic Fatigue Syndrome
☐ Persian Gulf and Afghanistan Infectious Diseases
☐ HIV and Related Illnesses
☐ Infectious Disease
☐ Systemic Lupus Erythematosus and other Immune Disorders
☐ Nutritional Deficiencies
☐ Tuberculosis

xvii. Additional Questionnaires
Check all that apply and complete the corresponding Questionnaire(s):
☐ Cold Injury Residuals

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

3. Diagnoses that are not addressed on other questionnaires.
Provide a list of the Veteran's diagnoses that have not been addressed on other questionnaires:

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

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

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

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

4. Functional impact
Does the Veteran's condition(s) that are etiologically related to his or her prisoner of war experience impact his or her ability to work?
☐ Yes ☐ No
If yes, describe the impact of each of the Veteran's prisoner of war related conditions, providing one or more examples:
_____

5. Remarks, if any: _____

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

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

6.8. DBQ General Medical - Compensation

Name of patient/Veteran: _____SSN: _____

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

1. <u>Medical history</u>

Perform a thorough review of all body systems. Based on this review, complete the sections below that pertain to the Veteran's symptoms. Complete the appropriate Questionnaire(s) based on your selections below.

i. Is there a skin and/or scar condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Skin Diseases
☐ Scars

ii. Is there a hemic and/or lymphatic condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Hematologic (including Anemia) and Lymphatic (Including Non-Hodgkin's Lymphoma)
☐ Hairy Cell & Other B-Cell Leukemias

iii. Is there an eye condition? ☐ Yes ☐ No
If yes, complete the Eyes Questionnaire.
Note: Vision evaluations must be conducted by a specialist.

iv. Is there an ear condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Hearing Loss and Tinnitus
☐ Ear Conditions
Note: Audio evaluations must be conducted by a specialist.

v. Is there a nose, sinuses, mouth and/or throat condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Sinusitis/Rhinitis and Other Conditions of the Nose, Throat, Larynx and Pharynx
☐ Loss of Sense of Smell and/or Taste
☐ Oral and Dental Conditions (including mouth, lips and tongue)
☐ Temporomandibular Joint

vi. Is there a respiratory condition other than tuberculosis? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Respiratory Conditions (other than tuberculosis and sleep apnea)
☐ Sleep Apnea

vii. Is there a disorder of the breast? ☐ Yes ☐ No
If yes, complete the Disorders of the Breast Questionnaire.

viii. Is there a cardiovascular condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Ischemic Heart Disease

☐ Artery & Vein Conditions (vascular diseases including varicose veins)
☐ Hypertension
☐ Heart Disease (including arrhythmias, valvular disease, and cardiac surgery)

ix. Is there an abdomen and/or digestive condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Esophageal Disorders (GERD and Hiatal Hernia)
☐ Gallbladder and Pancreas
☐ Infectious Intestinal Conditions
☐ Intestinal Surgery
☐ Intestinal Conditions (other than Surgical and Infectious)
☐ Hepatitis, Cirrhosis, and Other Liver Conditions
☐ Peritoneal Adhesions
☐ Stomach and Duodenal Conditions
☐ Abdominal, Inguinal, and Femoral Hernias
☐ Rectum and Anus (Including Hemorrhoids)

x. Is there a male genitourinary condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Kidney Conditions
☐ Male Reproductive Organs
☐ Prostate Cancer
☐ Urinary Tract (including Bladder and Urethral) Conditions

xi. Is there a female genitourinary condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Gynecological Conditions
☐ Kidney Conditions
☐ Urinary Tract (including Bladder and Urethral) Conditions

xii. Is there a musculoskeletal condition? ☐ Yes ☐ No
a. If yes, check all that apply and complete the corresponding Questionnaire(s):

<u>Spine</u>
☐ Back (Thoracolumbar Spine) Conditions
☐ Neck (Cervical Spine) Conditions

<u>Upper Extremities</u>
☐ Hands and Fingers
☐ Wrist
☐ Elbow and Forearm
☐ Shoulder and Arm

<u>Lower Extremities</u>
☐ Flatfeet
☐ Foot (other than Flatfeet)
☐ Ankle
☐ Knee and Lower Leg
☐ Hip and Thigh

<u>Miscellaneous</u>
☐ Amputations
☐ Fibromyalgia
☐ Osteomyelitis
☐ Muscle Injuries
☐ Non-degenerative Arthritis (including inflammatory, autoimmune, crystalline and infectious arthritis)

and Dysbaric Osteonecrosis

b. Are there joint manifestations of osteoporosis/osteopenia? ☐ Yes ☐ No
If yes, complete appropriate Questionnaire for affected joint(s)/spine)

xiii. Is there an endocrine and/or metabolic condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Diabetes Mellitus
☐ Thyroid and Parathyroid
☐ Endocrine Diseases (other than Thyroid, Parathyroid, or Diabetes Mellitus)

xiv. Is there a neurological condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Parkinson's Disease
☐ Amyotrophic Lateral Sclerosis (ALS)
☐ Cranial Nerves Diseases
☐ Diabetic Sensory-Motor Peripheral Neuropathy
☐ Disease of the Central Nervous System
☐ Fibromyalgia
☐ Narcolepsy
☐ Headaches (including Migraine Headaches)
☐ Multiple Sclerosis (MS)
☐ Peripheral Nerve Disorder
☐ Seizure Disorder (Epilepsy)
☐ Initial Evaluation of Residuals of Traumatic Brain Injury (I-TBI)
(The I-TBI Questionnaire can only be completed by a VHA specialist)
☐ Review Evaluation of Residuals of Traumatic Brain Injury (R-TBI)

xv. Is there a psychiatric condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Eating Disorders
☐ Initial Evaluation of PTSD (Initial PTSD Questionnaire can only be completed by VHA specialist)
☐ Mental Disorders (Other Than PTSD)
☐ Review Evaluation of PTSD
Note: Mental disorder evaluations must be conducted by a specialist.

xvi. Is there an infectious disease, an immune disorder, and/or nutritional deficiency?
☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Chronic Fatigue Syndrome
☐ Persian Gulf and Afghanistan Infectious Diseases
☐ HIV and Related Illnesses
☐ Infectious Diseases
☐ Systemic Lupus Erythematosus or other Immune Disorders
☐ Nutritional Deficiencies
☐ Tuberculosis

xvii. Additional Questionnaires
Check all that apply and complete the corresponding Questionnaire(s):
☐ Cold Injury Residuals
☐ Prisoner of War Protocol
☐ Gulf War Protocol (Undiagnosed Illness and Unexplained Chronic Multisymptom Illness)

2. Diagnoses that are not addressed on other questionnaires.
Provide a list of the Veteran's diagnoses that have not been addressed on other questionnaires:

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

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

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

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

3. Evidence review
Were medical or other pertinent records/evidence available for review as part of this examination?
☐ Yes ☐ No
If yes, indicate evidence/records reviewed as part of this examination (check all that apply):
- ☐ VA claims file (C-file)
  If checked, documents listed separately below that are included in a C-file do not need to be additionally indicated.
- ☐ Veterans Health Administration medical records (CPRS treatment records)
- ☐ Civilian medical records
- ☐ Military service treatment records
- ☐ Military service personnel records
- ☐ Military enlistment examination
- ☐ Military separation examination
- ☐ Military post-deployment questionnaire
- ☐ Department of Defense Form 214 separation document
- ☐ Previous disability decision letters
- ☐ Correspondence and non-medical documents related to condition
- ☐ Interviews with collateral witnesses (family and others who have known the Veteran before and after military service)
- ☐ Medical evidence brought to exam by Veteran
  If checked, describe: _____
- ☐ Social and Industrial Survey or other social work survey
- ☐ Other, describe: _____

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

☐ Yes ☐ No
If yes, describe (brief summary): _____

5. Functional impact of each additional diagnosis not addressed on other questionnaires.
Do the Veteran's condition(s) impact his or her ability to work?
☐ Yes ☐ No
If yes, describe the impact of each condition(s), providing one or more examples:
_____

6. Remarks, if any: _____

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

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

6.9. DBQ General Medical - Pension

Name of patient/Veteran: _____SSN: _____

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

1.Diagnosis

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

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

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

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

If there are additional disabling conditions, list using above format: _____

2. Medical history

a. Comment on the course, treatment, and symptoms for each diagnosis listed above:
NOTE: Mental, Dental, Vision, and Audio evaluations must be conducted by a specialist. Complete the corresponding Questionnaire(s), as appropriate.

Diagnosis #1: _____
Diagnosis #2: _____
Diagnosis #3: _____

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

b. Is the Veteran currently a patient in a nursing home for long-term care because of disability?
☐ Yes ☐ No

c. Is the Veteran currently hospitalized?
☐ Yes ☐ No
If yes, indicate the date of entrance into the hospital: _____
If yes, indicate the length of time (months) hospitalized:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 or more

3. Employment History

a. Is the Veteran currently employed?
☐ Yes ☐ No
If yes, describe the Veteran's current employment:
☐ Full time ☐ Part time ☐ Casual/Seasonal

Clinician Notes regarding current employment: _____

b. Does the Veteran's above listed medical conditions prevent him or her from securing or following a substantially gainful occupation?
☐ Yes ☐ No
If yes, are any of these conditions likely to be permanently disabling?
☐ Yes, list: _____
☐ No

4. Remarks, if any: _____

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

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

6.10. DBQ Gulf War General Medical Examination

Name of patient/Veteran: _____SSN: _____

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

1. Definitions

VA statutes and regulations provide for service connecting certain chronic disability patterns based on exposure to environmental hazards experienced during military service in Southwest Asia. The environmental hazards may have included: exposure to smoke and particles from oil well fires; exposure to pesticides and insecticides; exposure to indigenous infectious diseases; exposure to solvent and fuel fumes; ingestion of pyridostigmine bromide tablets, as a nerve gas antidote; the combined effect of multiple vaccines administered upon deployment; and inhalation of ultra fine-grain sand particles. In addition, there may have been exposure to smoke and particles from military installation "burn pit" fires that incinerated a wide range of toxic waste materials.

The chronic disability patterns associated with these Southwest Asia environmental hazards have two distinct outcomes. One is referred to as "undiagnosed illnesses" and the other as "diagnosed medically unexplained chronic multisymptom illnesses**". "**An undiagnosed illness is established when findings are present that cannot be attributed to a known,clearly defined diagnosis, after all likely diagnostic possibilities for such abnormalities have been ruled out." Examples of medically unexplained chronic multi-symptom illnesses include, but are not limited to: (1) chronic fatigue syndrome, (2) fibromyalgia, and (3) irritable bowel syndrome. Diseases of "partially explained etiology," such as diabetes or multiple sclerosis, are not considered by VA to be in the category of medically unexplained chronic multisymptom illnesses.

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

Fatigue
Signs or symptoms involving the skin
Headache
Muscle pain
Joint pain
Neurological signs and symptoms
Neuropsychological signs or symptoms
Upper or lower respiratory system signs or symptoms
Sleep disturbances
Gastrointestinal signs or symptoms
Cardiovascular signs or symptoms
Abnormal weight loss
Menstrual disorders

2. Medical history

2a. Perform a thorough review of all body systems. Based on this review, complete the sections below that pertain to the Veteran's symptoms. Complete the appropriate Questionnaire(s) based on your selections below.

a. Is there a skin and/or scar condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Skin Diseases
☐ Scars

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

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

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

☐ Hairy Cell & Other B-Cell Leukemias

c. Is there an eye condition? ☐ Yes ☐ No

If yes, complete the Eyes Questionnaire.

Note: Vision evaluations must be conducted by a specialist.

d. Is there an ear condition? ☐ Yes ☐ No

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

☐ Hearing Loss and Tinnitus

☐ Ear Conditions

Note: Audio evaluations must be conducted by a specialist.

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

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

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

☐ Loss of Sense of Smell and/or Taste

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

☐ Temporomandibular Joint

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

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

☐ Respiratory Conditions (other than tuberculosis and sleep apnea)

☐ Sleep Apnea

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

If yes, complete the Breast Conditions & Disorders Questionnaire.

h. Is there a cardiovascular condition? ☐ Yes ☐ No

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

☐ Ischemic Heart Disease

☐ Artery & Vein Conditions (vascular diseases including varicose veins)

☐ Hypertension

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

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

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

☐ Esophageal Conditions (GERD and Hiatal Hernia)

☐ Gallbladder and Pancreas

☐ Infectious Intestinal Disorders (including bacterial and parasitic infections)

☐ Intestinal Surgery (bowel resection, colostomy, and ileostomy)

☐ Intestinal Conditions (other than Surgical and Infectious)

☐ Hepatitis, Cirrhosis, and Other Liver Conditions

☐ Peritoneal Adhesions

☐ Stomach and Duodenal Conditions

☐ Abdominal, Inguinal, and Femoral Hernias

☐ Rectum and Anus (Including Hemorrhoids)

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

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

☐ Kidney Conditions

☐ Male Reproductive System

☐ Prostate Cancer
☐ Urinary Tract (including Bladder and Urethral) Conditions

k. Is there a female genitourinary or reproductive system condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Gynecological Conditions
☐ Kidney Conditions
☐ Urinary Tract (including Bladder and Urethral) Conditions

l. Is there a musculoskeletal condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):

Spine
☐ Back (Thoracolumbar Spine) Conditions
☐ Neck (Cervical Spine) Conditions

Joints and extremities
☐ Ankle
☐ Elbow and Forearm
☐ Hands and Fingers
☐ Hip and Thigh
☐ Knee and Lower Leg
☐ Shoulder and Arm☐ Wrist

Feet
☐ Flatfeet
☐ Foot (other than Flatfeet)

Miscellaneous
☐ Amputations
☐ Fibromyalgia
☐ Osteomyelitis
☐ Muscle Injuries
☐Non-degenerative Arthritis (including inflammatory, autoimmune, crystalline and infectious arthritis) and Dysbaric Osteonecrosis

m. Is there an endocrine and/or metabolic condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Diabetes Mellitus
☐ Thyroid and Parathyroid
☐ Endocrine Diseases (other than Thyroid, Parathyroid, or Diabetes Mellitus)

n. Is there a neurological condition? ☐ Yes ☐ No
If yes, check all that apply and complete the corresponding Questionnaire(s):
☐ Parkinson's Disease
☐ Amyotrophic Lateral Sclerosis (ALS)
☐ Cranial Nerves Diseases
☐ Diabetic Sensory-Motor Peripheral Neuropathy
☐ Disease of the Central Nervous System
☐ Fibromyalgia
☐ Narcolepsy
☐ Headaches (including Migraine Headaches)
☐ Multiple Sclerosis (MS)
☐ Peripheral Nerves

☐ Seizure Disorders (Epilepsy)

☐ Traumatic Brain Injury (Initial or Review)

NOTE: (The Initial and Review TBI Questionnaire can only be completed by a VA clinician who has completed the TBI C&P certification. The initial diagnosis of TBI must be made by a specialist, but a certified generalist can complete the disability exam for TBI.)

o. Is there a psychiatric condition? ☐ Yes ☐ No

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

☐ Eating Disorders
☐ Mental Disorders (Other Than PTSD)
☐ PTSD (Initial or Review)

Note: Mental evaluations must be conducted by a specialist.

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

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

☐ Chronic Fatigue Syndrome
☐ Persian Gulf and Afghanistan Infectious Diseases
☐ HIV and Related Illnesses
☐ Infectious Diseases
☐ Systemic Lupus Erythematosus and other Autoimmune Disorders
☐ Nutritional Deficiencies
☐ Tuberculosis

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

☐ Yes ☐ No

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

☐ Cold Injury Residuals
☐ Former Prisoner of War (POW) Protocol

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

☐ Yes ☐ No

If yes, complete the following for each:

Diagnosis #1: _____
ICD code(s): _____
Date of diagnosis: _____
Questionnaire (DBQ): _____

Diagnosis #2: _____
ICD code(s): _____
Date of diagnosis: _____
Questionnaire (DBQ): _____

Diagnosis #3: _____
ICD code(s): _____
Date of diagnosis: _____
Questionnaire (DBQ): _____

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

2c. Does the Veteran report any additional signs and/or symptoms not addressed above?
☐ Yes ☐ No

If yes, check all that apply
☐ Fatigue
☐ Signs or symptoms involving the skin
☐ Headache
☐ Muscle pain
☐ Joint pain
☐ Neurological signs and symptoms
☐ Neuropsychological signs or symptoms
☐ Upper or lower respiratory system signs or symptoms
☐ Sleep disturbances
☐ Gastrointestinal signs or symptoms
☐ Cardiovascular signs or symptoms
☐ Abnormal weight loss
☐ Menstrual disorders
☐ Other, describe: _____

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

3. Functional impact
Based on your examination and/or the Veteran's history, do any of the signs and/or symptoms checked in question 2.c impact his or her ability to work?
☐ Yes ☐ No
If yes, for each sign and/or symptom that impacts his or her ability to work, describe impact, providing one or more examples: _____

4. Remarks, if any: _____

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

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

6.11. DBQ HIV-Related Illness

Name of patient/Veteran:_____ SSN:_____

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

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with HIV or an HIV-related illness?
☐ Yes ☐ No

If yes, provide only diagnoses that pertain to HIV-related illnesses or complications:
Diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____

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

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

If there are additional diagnoses that pertain to HIV-related illness, list using above format: _____

2. Medical history

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

b. Is continuous medication required for control of HIV-related illness(es)?
☐ Yes ☐ No
If yes, list only those medications required for the Veteran's HIV-related illness(es) (If the Veteran has more than one HIV-related illness(es), specify the condition for which each medication is required):
_____

c. Does the Veteran have any complications due to current or previous medications taken for HIV-related illness(es)?
☐ Yes ☐ No
If yes, list medication and describe complication(s) due to medication(s): _____

3. Signs, symptoms and findings

Does the Veteran have any signs, symptoms or findings attributable to an HIV-related illness?
☐ Yes ☐ No
If yes, check all that apply:

a. ☐ Constitutional symptoms (fever, weight loss, fatigue, malaise, decreased appetite, etc.) attributable to an HIV-related illness
If checked, indicate frequency and severity:
☐ Refractory ☐ Recurrent
Describe constitutional symptoms: _____

b. ☐ Diarrhea attributable to an HIV-related illness

If checked, indicate frequency and severity:
☐ Refractory ☐ Intermittent
Describe: _____

c. ☐ Weight loss attributable to an HIV-related illness
If checked, provide baseline weight: _____ and current weight: _____
(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

d. ☐ Nausea attributable to an HIV-related illness
If checked, indicate severity:
☐Mild ☐ Transient ☐ Recurrent ☐ Periodic
Indicate frequency of episodes of nausea per year:
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

e. ☐ Vomiting attributable to an HIV-related illness
If checked, indicate severity:
☐Mild ☐ Transient ☐ Recurrent ☐ Periodic
Indicate frequency of episodes of vomiting per year:
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
Indicate average duration of episodes of vomiting:
☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

f. ☐ Anemia of chronic disease attributable to an HIV-related illness
If checked, describe: _____
Provide hemoglobin/hematocrit in Diagnostic testing section.

g. ☐ Hairy cell leukoplakia
If checked, is Veteran currently affected by hairy cell leukoplakia?
☐ Yes ☐ No
Provide date(s) of onset, treatment and course: _____

h. ☐ Oral candidiasis
If checked, is Veteran currently affected by oral candidiasis?
☐ Yes ☐ No
Provide date(s) of onset, treatment and course: _____

i. ☐ Other, describe: _____

4. Complications

a. Does the Veteran have any complications attributable to an HIV-related illness or its treatment?
☐ Yes ☐ No
If yes, check all that apply:

☐ HIV-associated neurocognitive disorder
If checked, a Mental Disorders Questionnaire must also be completed.
☐ HIV-associated neuropathy, radiculopathy or myelopathy
If checked, a Peripheral Nerve Questionnaire must also be completed.
☐ HIV-associated retinopathy
If checked, an Eye Questionnaire must also be completed.
☐ HIV-associated cardiopathy
If checked, a Heart Questionnaire must also be completed.
☐ HIV-associated pulmonary hypertension
If checked, a Respiratory Questionnaire must also be completed.
☐ HIV-induced enteropathy
If checked, the appropriate gastrointestinal Questionnaire must also be completed.
☐ HIV-associated nephropathy
If checked, a Kidney Questionnaire must also be completed.

☐ HIV-associated impaired lipid and glucose metabolism
☐ HIV-associated wasting
☐ Lipodystrophy
☐ Myopathy
☐ Other, describe: _____

b. For each checked condition (except those conditions for which an additional DBQ is completed), describe (providing date of onset, and brief summary of symptoms, treatment and course): _____

5. Infectious and oncologic complications

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

☐ Yes ☐ No

If yes, check all that apply:

☐ Oral candidiasis
☐ Tuberculosis
☐ Hepatitis
☐ Pneumocystosis
☐ Toxoplasmosis
☐ Cryptococcosis
☐ Cerebral toxoplasmosis
☐ Cryptococcal meningoencephalitis
☐ Viral meningoencephalitis
☐ Cytomegalovirus
☐ Herpes simplex virus
☐ Varicella zoster virus
☐ Progressive multifocal leukoencephalopathy
☐ Neurosyphilis
☐ Primary central nervous system lymphoma
☐ Other, describe: _____

For each checked condition (except those conditions for which an additional DBQ is completed), describe (providing date of onset, and brief summary of symptoms, treatment and course): _____

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

☐ Yes ☐ No

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

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

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

a. Does the Veteran have depression, cognitive impairment or dementia, or any other mental health conditions attributable to HIV-related illness or its treatment?

☐ Yes ☐ No

b. Does the Veteran's mental health condition(s), as identified in the question above, result in gross impairment in thought processes or communication?

☐ Yes ☐ No

If No, also complete a Mental Disorder Questionnaire (schedule with appropriate provider).
If yes, briefly describe the Veteran's mental health condition: _____

7. Summary

Based on symptoms and findings from this exam, complete the following section to provide a summary of the severity of the Veteran's HIV-related condition. This summary provides useful information for VA purposes.

Select all that apply from each level:

a. Level I

☐ Asymptomatic, with or without lymphadenopathy or decreased T4 cell count

b. Level II
☐ Symptomatic, with current T4 cell of 200 or more and less than 500, and on approved medication(s) (For VA purposes, approved medications include medications prescribed as part of a research protocol at an accredited medical institution.)
☐ Evidence of depression with employment limitations
☐ Evidence of memory loss with employment limitations

c. Level III
☐ Recurrent constitutional symptoms, intermittent diarrhea, and on approved medications
☐ Current T4 cell count less than 200
☐ Hairy cell leukoplakia
☐ Oral candidiasis

d. Level IV
☐ Refractory constitutional symptoms
☐ Diarrhea and pathological weight loss
☐ Development of AIDS-related opportunistic infection or neoplasm

e. Level V
☐ AIDS with recurrent opportunistic infections
☐ Secondary diseases afflicting multiple body systems
☐ HIV-related illness with debility and progressive weight loss, without remission or few or brief remissions

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

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

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

9. Diagnostic testing

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

a. Has laboratory testing been performed?
☐ Yes ☐ No
If yes, check all that apply:
☐ CD4 lymphocyte count: _____ Date: _____
☐ Lowest (nadir) CD4 lymphocyte count, if available: _____ Date, if known: _____
☐ CBC (if anemia of chronic disease attributable to HIV-related illness is suspected or present):
Date: _____ Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____
☐ Other test, specify: _____ Date of test: _____ Results: _____

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

c. Has an HIV Dementia Scale been administered (if indicated)?
☐ Yes ☐ No
Results: _____ Date: _____

d. Has neuropsychiatric testing been performed for cognitive impairment (if indicated)?
☐ Yes ☐ No
Results: _____ Date: _____

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

10. Functional impact
Do any of the Veteran's HIV-related illnesses or complications impact his or her ability to work?
☐ Yes ☐ No
If yes, describe impact of each of the Veteran's HIV-related illnesses, providing one or more examples:_____
11. Remarks, if any:
_____

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

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

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

Name of patient/Veteran: _____ SSN: _____

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

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with an infectious disease?
☐ Yes ☐ No

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

☐ Malaria ICD code: _____ Date of diagnosis: _____
☐ Asiatic Cholera ICD code: _____ Date of diagnosis: _____
☐ Visceral Leishmaniasis ICD code: _____ Date of diagnosis: _____
☐ Leprosy (Hansen's disease) ICD code: _____ Date of diagnosis: _____
☐ Lymphatic Filariasis ICD code: _____ Date of diagnosis: _____
☐ Bartonellosis ICD code: _____ Date of diagnosis: _____
☐ Plague ICD code: _____ Date of diagnosis: _____
☐ Relapsing Fever ICD code: _____ Date of diagnosis: _____
☐ Rheumatic Fever ICD code: _____ Date of diagnosis: _____
☐ Endocarditis ICD code: _____ Date of diagnosis: _____
☐ Syphilis ICD code: _____ Date of diagnosis: _____
☐ Brucellosis ICD code: _____ Date of diagnosis: _____
☐ Typhus Scrub ICD code: _____ Date of diagnosis: _____
☐ Melioidosis ICD code: _____ Date of diagnosis: _____
☐ Lyme Disease ICD code: _____ Date of diagnosis: _____
☐ Parasitic Disease, NOS ICD code: _____ Date of diagnosis: _____
☐ Other, specify:

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

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

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

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

2. Medical history

a. Describe the history (including onset and course) of the Veteran's infectious disease condition(s): ____

b. Is continuous medication required for control of an infectious disease condition?
☐ Yes ☐ No
If yes, list only those medications required for the Veteran's infectious disease condition (If the Veteran

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

3. Status, symptoms, and residuals
Complete the following section for each infectious disease condition:

Disease #1: _____
a. Status of disease #1:
☐ Active ☐ Inactive
If inactive, date condition became inactive: _____

b. Does the Veteran have symptoms attributable to disease: #1?
☐ Yes ☐ No
If yes, describe: _____

c. Does the Veteran have residuals attributable to disease: #1?
☐ Yes ☐ No
If yes, describe: _____

If the Veteran has symptoms or residuals, ALSO complete the appropriate Questionnaire for each symptomatic or residual condition (such as Skin, Heart, Peripheral or Central Nervous System, Respiratory and appropriate Joint and Gastrointestinal Questionnaire).

Disease #2: _____
a. Status of disease #2:
☐ Active ☐ Inactive
If inactive, date condition became inactive: _____

b. Does the Veteran have symptoms attributable to disease: #2?
☐ Yes ☐ No
If yes, describe: _____

c. Does the Veteran have residuals attributable to disease: #2?
☐ Yes ☐ No
If yes, describe: _____

If the Veteran has symptoms or residuals, ALSO complete the appropriate Questionnaire for each symptomatic or residual condition (such as Skin, Heart, Peripheral or Central Nervous System, Respiratory and appropriate Joint and Gastrointestinal Questionnaire).

Disease #3: _____
a. Status of disease #3:
☐ Active ☐ Inactive
If inactive, date condition became inactive: _____

b. Does the Veteran have symptoms attributable to disease: #3?
☐ Yes ☐ No
If yes, describe: _____
c. Does the Veteran have residuals attributable to disease: #3?
☐ Yes ☐ No
If yes, describe: _____

If the Veteran has symptoms or residuals, ALSO complete the appropriate Questionnaire for each symptomatic or residual condition (such as Skin, Heart, Peripheral or Central Nervous System, Respiratory and appropriate Joint and Gastrointestinal Questionnaire).

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

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

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

☐ Yes ☐ No

If yes, describe (brief summary): _____

5. Diagnostic testing

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

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

☐ Yes ☐ No

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

6. Functional impact

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

☐ Yes ☐ No

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

_____

7. Remarks, if any: _____

Physician signature: _____ Date: _____

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

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

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

Name of patient/Veteran: _____SSN: _____

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

SECTION I

1. Diagnosis

Does the Veteran now have or has he/she ever had a traumatic brain injury (TBI) or any residuals of a TBI?
☐ Yes ☐ No

If yes, select the Veteran's condition (check all that apply):
☐ Traumatic brain injury (TBI) ICD code: _____ Date of diagnosis: _____
☐ Other diagnosed residuals attributable to TBI, specify:

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

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

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

Other diagnosis #4: _____
ICD code: _____
Date of diagnosis: _____

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

2. Medical history

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

b. Was the Veteran exposed to any blasts?
☐ Yes ☐ No
If yes, indicate number of blasts:
☐ 1 ☐ 2 ☐ 3 ☐ More than 3
Date of first blast exposure: _____
Date of last blast exposure: _____
How many blasts were severe enough to knock Veteran down or cause injury?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ More than 3

c. Does the Veteran's treatment plan include taking continuous medication for the diagnosed condition?
☐ Yes ☐ No
If yes, list only those medications used for the diagnosed condition: _____

3. Evidence review

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

☐ Yes ☐ No

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

☐ VA claims file (C-file)

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

☐ Veterans Health Administration medical records (CPRS treatment records)
☐ Civilian medical records
☐ Military service treatment records
☐ Military service personnel records
☐ Military enlistment examination
☐ Military separation examination
☐ Military post-deployment questionnaire
☐ Department of Defense Form 214 separation document
☐ Previous disability decision letters
☐ Correspondence and non-medical documents related to condition
☐ Interviews with collateral witnesses (family and others who have known the Veteran before and after military service)
☐ Medical evidence brought to exam by Veteran

If checked, describe: _____

☐ Other, describe: _____

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

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

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

1. Memory, attention, concentration, executive functions

☐ No complaints of impairment of memory, attention, concentration, or executive functions
☐ A complaint of mild memory loss (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing
☐ Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment
☐ Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment
☐ Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment

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

2. Judgment

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

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

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

3. Social interaction
☐ Social interaction is routinely appropriate
☐ Social interaction is occasionally inappropriate
☐ Social interaction is frequently inappropriate
☐ Social interaction is inappropriate most or all of the time

If the Veteran's social interaction is not routinely appropriate, describe (brief summary): _____

4. Orientation
☐ Always oriented to person, time, place, and situation
☐ Occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation
☐ Occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation
☐ Often disoriented to two or more of the four aspects (person, time, place, situation) of orientation
☐ Consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation

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

5. Motor activity (with intact motor and sensory system)
☐ Motor activity normal
☐ Motor activity is normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function)
☐ Motor activity is mildly decreased or with moderate slowing due to apraxia
☐ Motor activity moderately decreased due to apraxia
☐ Motor activity severely decreased due to apraxia

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

6. Visual spatial orientation
☐ Normal
☐ Mildly impaired. Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system)
☐ Moderately impaired. Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS (global positioning system)
☐ Moderately severely impaired. Gets lost even in familiar surroundings, unable to use assistive devices such as GPS (global positioning system)
☐ Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment

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

7. Subjective symptoms
☐ No subjective symptoms
☐ Subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples are: mild or occasional headaches, mild anxiety

☐ Three or more subjective symptoms that mildly interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light
☐ Three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days

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

8. Neurobehavioral effects

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

☐ No neurobehavioral effects
☐ One or more neurobehavioral effects that do not interfere with workplace interaction or social interaction.
☐ One or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them
☐ One or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them
☐ One or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction, or both on most days or that occasionally require supervision for safety of self or others

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

9. Communication

☐ Able to communicate by spoken and written language (expressive communication) and to comprehend spoken and written language.
☐ Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas.
☐ Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than occasionally but less than half of the time. Can generally communicate complex ideas
☐ Inability to communicate either by spoken language, written language, or both, at least half of the time but not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs
☐ Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both. Unable to communicate basic needs

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

10. Consciousness

☐ Normal
☐ Persistent altered state of consciousness, such as vegetative state, minimally responsive state, coma.
If checked, describe altered state of consciousness (brief summary): _____

SECTION III

1. Residuals

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

☐ Yes ☐ No
If yes, check all that apply:

- ☐ Motor dysfunction
  If checked, ALSO complete specific Joint or Spine Questionnaire for the affected joint or spinal area.
- ☐ Sensory dysfunction
  If checked, ALSO complete appropriate Cranial or Peripheral Nerve Questionnaire.
- ☐ Hearing loss and/or tinnitus
  If checked, ALSO complete a Hearing Loss and Tinnitus Questionnaire.
- ☐ Visual impairment
  If checked, ALSO complete an Eye Questionnaire.
- ☐ Alteration of sense of smell or taste
  If checked, ALSO complete a Loss of Sense of Smell and Taste Questionnaire.
- ☐ Seizures
  If checked, ALSO complete a Seizure Disorder Questionnaire.
- ☐ Gait, coordination, and balance
  If checked, ALSO complete appropriate Questionnaire for underlying cause of gait and balance disturbance, such as Ear Questionnaire.
- ☐ Speech (including aphasia and dysarthria)
  If checked, ALSO complete appropriate Questionnaire.
- ☐ Neurogenic bladder
  If checked, ALSO complete appropriate Genitourinary Questionnaire.
- ☐ Neurogenic bowel
  If checked, ALSO complete appropriate Intestines Questionnaire.
- ☐ Cranial nerve dysfunction
  If checked, ALSO complete a Cranial Nerves Questionnaire.
- ☐ Skin disorders
  If checked, ALSO complete a Skin and/or Scars Questionnaire.
- ☐ Endocrine dysfunction
  If checked, ALSO complete an Endocrine Conditions Questionnaire.
- ☐ Erectile dysfunction
  If checked, ALSO complete Male Reproductive Conditions Questionnaire.
- ☐ Headaches, including Migraine headaches
  If checked, ALSO complete a Headache Questionnaire.
- ☐ Meniere's disease
  If checked, ALSO complete an Ear Conditions Questionnaire.
- ☐ Mental disorder (including emotional, behavioral, or cognitive)
  If checked, ALSO complete Mental Disorders or PTSD Questionnaire.
- ☐ Other, describe: _____
  If checked, ALSO complete appropriate Questionnaire.

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

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

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

3. Diagnostic testing

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

a. Has neuropsychological testing been performed?
☐ Yes ☐ No
If yes, provide date: _____
Results: _____

b. Have diagnostic imaging studies or other diagnostic procedures been performed?
☐ Yes ☐ No
If yes, check all that apply:
☐ Magnetic resonance imaging (MRI)
Date: _____ Results: _____
☐ Computed tomography (CT)
Date: _____ Results: _____
☐ EEG
Date: _____ Results: _____
☐ Other, describe: _____
Date: _____ Results: _____

c. Has laboratory testing been performed?
☐ Yes ☐ No
If yes, specify tests: _____ Date: _____ Results: _____

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

4. Functional impact

Do any of the Veteran's residual conditions attributable to a traumatic brain injury impact his or her ability to work?
☐ Yes ☐ No
If yes, describe impact of each of the Veteran's residual conditions attributable to a traumatic brain injury, providing one or more examples: _____

5. Remarks, if any: _____

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

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

6.14. DBQ Loss of Sense of Smell and or Taste

Name of patient/Veteran: _____SN: _____

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

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with loss of sense of smell or taste?
☐ Yes ☐ No

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

☐ Anosmia (inability to detect any odor) ICD code: _____ Date of diagnosis: _____
☐ Hyposmia (reduced ability to detect odors) ICD code: _____ Date of diagnosis: _____
☐ Ageusia (complete lack of taste) ICD code: _____ Date of diagnosis: _____
☐ Hypogeusia (decrease in sense of taste) ICD code: _____ Date of diagnosis: _____
☐ Other, specify:

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

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

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

2. Medical history

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

3. Symptoms

a. Does the Veteran currently have loss of sense of smell?
☐ Yes ☐ No

If yes, indicate severity:
☐Partial
☐Complete

If yes, is there a known anatomical or pathological basis for this condition?
☐ Yes ☐ No
If yes, describe_____

b. Does the Veteran currently have loss of sense of taste (unable to detect sweet, salty, sour, or bitter tastes)?
☐ Yes ☐ No

If yes, indicate severity:
☐Partial
☐Complete

If yes, is there a known anatomical or pathological basis for this condition?
☐ Yes ☐ No

If yes, describe_____

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

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

☐ Yes ☐ No

If yes, describe (brief summary): _____

5. Diagnostic testing

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

a. Have imaging or laboratory studies been performed?

☐ Yes ☐ No

If yes, check all that apply:

☐ Magnetic resonance imaging (MRI) Date: _____ Results: _____
☐ Computed tomography (CT) Date: _____ Results: _____
☐ Other: _____ Date: _____ Results: _____

b. Has qualitative smell testing been performed?

☐ Yes ☐ No

If yes, complete the following:

Type of test: _____ Date: _____ Results: _____

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

☐ Yes ☐ No

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

6. Functional impact

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

☐ Yes ☐ No

If yes, describe the impact of each of the Veteran's conditions related to the loss of sense of smell or taste, providing one or more examples: _____

7. Remarks, if any: _____

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

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

6.15. DBQ Narcolepsy

Name of patient/Veteran: _____ SSN: _____

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

1. Diagnosis

Does the Veteran have or has he/she ever been diagnosed with narcolepsy?
☐ Yes ☐ No

If yes, check the appropriate diagnoses (check all that apply):
- ☐ Narcolepsy ICD code: _____ Date of diagnosis: _____
- ☐ Other, specify:
  - Other diagnosis #1: _____
  - ICD code: _____
  - Date of diagnosis: _____

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

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

2. Medical history

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

b. Is continuous medication required for control of narcolepsy?
☐ Yes ☐ No
If yes, list only those medications required for the Veteran's narcolepsy: _____

3. Findings, signs and symptoms

Does the Veteran have a confirmed diagnosis of narcolepsy with a history of narcoleptic episodes?
☐ Yes ☐ No
If yes, complete the following:

a. If yes, does the Veteran report any of the following findings, signs or symptoms?
☐ Yes ☐ No
If yes, check all that apply:
- ☐ Excessive daytime sleepiness
- ☐ Sleep attacks (strong urge to sleep, followed by short nap)
- ☐ Cataplexy (sudden loss of muscle tone while awake, resulting in brief inability to move)
- ☐ Sleep paralysis (inability to move on first awakening)
- ☐ Hallucinations

For all checked conditions or for any other conditions, describe: _____

b. Indicate frequency of narcoleptic episodes (check all that apply):
Number of narcoleptic episodes over past 6 months:
- ☐ 0-1
- ☐ 2 or more
  - If 2 or more over the past 6 months, indicate the average frequency of narcoleptic episodes:

☐ 0-4 per week
☐ 5-8 per week
☐ 9-10 per week
☐ More than 10 per week

If the Veteran has narcoleptic episodes, describe: _____

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

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

a. Have any imaging studies or diagnostic procedures been performed?
☐ Yes ☐ No
If yes, check all that apply:

☐ Polysomnogram (PSG)	Date: _____	Results: _____
☐ Multiple Sleep Latency Test (MSLT)	Date: _____	Results: _____
☐ Hypocretin level in cerebrospinal fluid (CSF)	Date: _____	Results: _____
☐ Other, describe: _____	Date: _____	Results: _____

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

6. Functional impact
Does the Veteran's narcolepsy impact his or her ability to work?
☐ Yes ☐ No
If yes, describe impact, providing one or more examples: _____

7. Remarks, if any: _____

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

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

6.16. DBQ Nutritional Deficiencies

Name of patient/Veteran: _____SSN: _____

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

1. Diagnosis

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

If yes, select the Veteran's condition (check all that apply):
☐ Avitaminosis
☐ Beriberi (Vitamin B1 or thiamine deficiency)
☐ Pellegra (Vitamin B3 or niacin deficiency)
☐ Other nutritional deficiency condition:
Other diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____

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

If there are additional diagnoses that pertain to nutritional deficiencies, list using above format: __

For all identified complications or residual conditions, ALSO complete additional Questionnaires as appropriate (such as skin, heart, peripheral nerves, etc.)

2. Medical history

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

b. Does the Veteran's nutritional deficiency condition require continuous medications for control?
☐ Yes ☐ No
If yes, list medications used for nutritional deficiency conditions: _____

3. Findings, signs and symptoms

a. Does the Veteran have any findings, signs or symptoms attributable to pellagra or avitaminosis?
☐ Yes ☐ No
If yes, indicate the choice that best describes the current severity:
☐ Confirmed diagnosis with nonspecific symptoms such as decreased appetite, weight loss, abdominal discomfort, weakness, inability to concentrate and irritability
☐ With stomatitis or achlorhydria or diarrhea
☐ With stomatitis, diarrhea, and symmetrical dermatitis
☐ With all of the symptoms listed above plus mental symptoms and impaired bodily vigor
☐ Marked mental changes, moist dermatitis, inability to retain nourishment, exhaustion, and cachexia
☐ Other, describe: _____

b. Does the Veteran have any findings, signs or symptoms attributable to active beriberi?
☐ Yes ☐ No

If yes, indicate the choice that best describes the current severity:

☐ Peripheral neuropathy with absent knee or ankle jerks and loss of sensation
☐ Symptoms such as weakness, fatigue, anorexia, dizziness, heaviness and stiffness of legs, headache, or sleep disturbance
☐ Cardiomegaly
☐ Peripheral neuropathy with foot drop or atrophy of thigh or calf muscles
☐ Congestive heart failure, anasarca, or Wernicke-Korsakoff syndrome
☐ Other, describe: _____

c. Does the Veteran have any findings, signs or symptoms attributable to residuals of beriberi?
☐ Yes ☐ No
If yes, describe residuals: _____

d. Does the Veteran have any findings, signs or symptoms attributable to conditions or residuals caused by any other vitamin deficiency?
☐ Yes ☐ No
If yes, describe: _____

For all checked answers for questions a-d, ALSO complete additional Questionnaires as appropriate (such as Mental Disorders, Skin, Heart, Peripheral Nerves, etc.)

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

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

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

5. Diagnostic testing

NOTE: If testing has been completed and reflects Veteran's current condition, further testing is not required.

Are there any significant diagnostic test findings and/or results?
☐ Yes ☐ No
If yes, describe: _____

6. Functional impact

Does the Veteran's nutritional deficiency condition(s) impact his or her ability to work?
☐ Yes ☐ No
If yes, describe impact of each of the Veteran's nutritional deficiency conditions, providing one or more examples:
_____

7. Remarks, if any: _____

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

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

6.17. DBQ Oral and Dental Conditions including Mouth, Lips and Tongue (other than Temporomandibular Joint Conditions)

Name of patient/Veteran: _____SSN: _____

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

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with an oral or dental condition?
☐ Yes ☐ No

If yes, select the Veteran's condition (check all that apply):
☐ Loss of any portion of mandible ICD code: _____ Date of diagnosis: _____
☐ Loss of any portion of maxilla ICD code: _____ Date of diagnosis: _____
☐ Malunion or nonunion of mandible ICD code: _____ Date of diagnosis: _____
☐ Malunion or nonunion of maxilla ICD code: _____ Date of diagnosis: _____
☐ Loss of teeth (for reasons other than periodontal disease)
ICD code: _____ Date of diagnosis: _____
☐ Temporomandibular joint disorder (TMJD)
If checked, complete the Temporomandibular Joint Questionnaire in lieu of this Questionnaire if that is the Veteran's only condition. If the Veteran has a TMJ condition AND additional oral or dental conditions, complete this Questionnaire and ALSO complete the Temporomandibular Joint Questionnaire.
☐ Limitation of motion of the temporomandibular joint due to causes other than temporomandibular joint disorder
If checked, complete this Questionnaire and ALSO complete the Temporomandibular Joint Questionnaire.
☐ Anatomical loss or injury of the mouth, lips or tongue
ICD code: _____ Date of diagnosis: _____
☐ Osteomyelitis or osteoradionecrosis of the mandible
ICD code: _____ Date of diagnosis: _____
☐ Oral neoplasm
If checked, specify: _____ ICD code: _____ Date of diagnosis: _____
☐ Periodontal disease
If this is the ONLY diagnosis checked, proceed to the signature section at the end of this form (for VA purposes this disease is not considered disabling)
☐ Other, specify:

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

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

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

NOTE: This Questionnaire is appropriate for bone loss due to trauma or disease such as osteomyelitis and not to the loss of the alveolar process as a result of periodontal disease, since such loss is not considered disabling.

2. Medical History

a. Describe the history (including onset and course) of the Veteran's oral and/or dental condition: _____

b. Is continuous medication required for control of an oral or dental condition?
☐ Yes ☐ No
If yes, list only those medications required for the Veteran's oral or dental conditions: _____

3. Mandible
Does the Veteran have any anatomical loss or bony injury of the mandible?
☐ Yes ☐ No
If yes, complete the following section:

a. Has the veteran lost any part of the mandible or mandibular ramus?
☐ Yes ☐ No
If yes, indicate severity (check all that apply):
- ☐ Loss of approximately 1/2 of the mandible, not involving the temporomandibular articulation
- ☐ Loss of approximately 1/2 of the mandible, involving the temporomandibular articulation
- ☐ Complete loss of the mandible between angles
- ☐ Loss of less than 1/2 the substance of mandibular ramus, not involving loss of continuity
  If checked, indicate side: ☐ Right ☐ Left ☐ Both
- ☐ Loss of whole or part of mandibular ramus, without loss of temporomandibular articulation
  If checked, indicate side: ☐ Right ☐ Left ☐ Both
- ☐ Loss of whole or part of mandibular ramus, involving loss of temporomandibular articulation
  If checked, indicate side: ☐ Right ☐ Left ☐ Both
- ☐ Other, describe: _____

b. Has the Veteran lost either condyloid process of the mandible?
☐ Yes ☐ No
If yes, indicate side: ☐ Right ☐ Left ☐ Both

c. Has the Veteran lost either coronoid process of the mandible?
☐ Yes ☐ No
If yes, indicate side: ☐ Right ☐ Left ☐ Both

d. Has the Veteran had an injury resulting in malunion or nonunion of the mandible?
☐ Yes ☐ No
If yes, indicate severity:
- ☐ Malunion with slight displacement
- ☐ Malunion with moderate displacement
- ☐ Malunion with severe displacement
- ☐ Nonunion, moderate
- ☐ Nonunion, severe
- ☐ Other, describe: _____

NOTE: The assessment of the severity of malunion or nonunion of the mandible is dependent upon degree of motion and relative loss of masticatory function.

4. Maxilla
Does the Veteran have any anatomical loss or bony injury of the maxilla?
☐ Yes ☐ No
If yes, complete the following section:

a. Has the Veteran lost any part of the maxilla?
☐ Yes ☐ No
If yes, indicate the severity:
- ☐ Loss of less than 25%
- ☐ Loss of 25 to 50%
- ☐ Loss of more than 50%

b. If the Veteran has lost any part of the maxilla, is the loss replaceable by prosthesis?
☐ Yes ☐ No ☐ Not applicable

c. Has the Veteran lost any part of the hard palate?
☐ Yes ☐ No
If yes, indicate the severity:
- ☐ Loss of less than 50%
- ☐ Loss of 50% or more

d. If the Veteran has lost any part of the hard palate, is the loss replaceable by prosthesis?
☐ Yes ☐ No ☐ Not applicable

e. Has the Veteran had an injury resulting in malunion or nonunion of the maxilla?
☐ Yes ☐ No
If yes, indicate severity:
- ☐ Malunion or nonunion with slight displacement
- ☐ Malunion or nonunion with moderate displacement
- ☐ Malunion or nonunion with severe displacement

5. Teeth
Does the Veteran have anatomical loss or bony injury of any teeth (other than that due to the loss of the alveolar process as a result of periodontal disease)?
☐ Yes ☐ No
If yes, complete the following section:

a. Is the loss of teeth due to loss of substance of body of maxilla or mandible without loss of continuity?
☐ Yes ☐ No

b. Is the loss of teeth due to trauma or disease (such as osteomyelitis)?
☐ Yes ☐ No
If yes, describe: _____

c. Can the masticatory surfaces be restored by suitable prosthesis?
☐ Yes ☐ No

d. Indicate the extent of loss of teeth from the selections below (check all that apply):
- ☐ All upper teeth
- ☐ All lower teeth
- ☐ All upper and lower posterior teeth (both right and left)
- ☐ All upper and lower anterior teeth (both right and left)
- ☐ All upper anterior teeth (both right and left)
- ☐ All lower anterior teeth (both right and left)
- ☐ All right upper and lower teeth
- ☐ All left upper and lower teeth
- ☐ None of the above

6. Mouth, lips, tongue and disfiguring scars
Does the Veteran have anatomical loss or injury of the mouth, lips or tongue?
☐ Yes ☐ No
If yes, complete the following section:

a. Does the Veteran have any disfiguring scars to the mouth or lips?
☐ Yes ☐ No
If yes, ALSO complete a Scars Questionnaire.

b. Does the Veteran have a mouth injury that results in impairment of mastication?

☐ Yes ☐ No
If yes, describe: _____

c. Does the Veteran have partial or complete loss of the tongue?
☐ Yes ☐ No
If yes, indicate severity:
☐ Loss of less than 1/2 of tongue
☐ Loss of 1/2 or more of tongue

d. Does the Veteran have a speech impairment caused by partial or complete loss of the tongue, or by any other tongue condition?
☐ Yes ☐ No
If yes, indicate severity:
☐ Marked speech impairment
If checked, describe: _____
☐ Inability to communicate by speech
If checked, describe: _____

7. Osteomyelitis/osteoradionecrosis

Does the Veteran now have or has he or she ever been diagnosed with osteomyelitis or osteoradionecrosis of the mandible?
☐ Yes ☐ No
If yes, ALSO complete Osteomyelitis Questionnaire.

8. Tumors and neoplasms

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

a. Is the neoplasm:
☐ Benign ☐ Malignant

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

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

☐ Yes ☐ No
If yes, list residual conditions and complications (brief summary): _____

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

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

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

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

10. Diagnostic testing

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

a. Have imaging studies or procedures been performed?
☐ Yes ☐ No
If yes, check all that apply:
☐ Panographic dental x-ray to demonstrate loss of teeth, mandible or maxilla
Date: _____ Results: _____
☐ Other x-rays Date: _____ Results: _____
☐ Magnetic resonance imaging (MRI) Date: _____ Results: _____
☐ Computed tomography (CT) Date: _____ Results: _____
☐ Other: _____ Date: _____ Results: _____

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

11. Functional impact

Does the Veteran's oral or dental condition impact his or her ability to work?
☐ Yes ☐ No
If yes, describe impact of each of the Veteran's oral or dental conditions, providing one or more examples:
_____

12. Remarks, if any: _____

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

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

6.18. DBQ Respiratory Conditions (other than Tuberculosis and Sleep Anpea)

Name of patient/Veteran: _____SSN: _____

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

SECTION I: DIAGNOSES

NOTE: The diagnosis section should be filled out AFTER the clinician has completed the evaluation.
Does the Veteran now have or has he/she ever been diagnosed with a respiratory condition?
☐ Yes ☐ No

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

☐ Asthma ICD code: _____ Date of diagnosis: _____
☐ Emphysema ICD code: _____ Date of diagnosis: _____
☐ Chronic obstructive pulmonary disease (COPD)
ICD code: _____ Date of diagnosis: _____
☐ Chronic bronchitis ICD code: _____ Date of diagnosis: _____
☐ Interstitial lung disease
If checked, specify: _____ ICD code: _____ Date of diagnosis: _____
(Interstitial lung diseases include but are not limited to asbestosis, diffuse interstitial fibrosis, interstitial pneumonitis, fibrosing alveolitis, desquamative interstitial pneumonitis, pulmonary alveolar proteinosis, eosinophilic granuloma of lung, drug-induced pulmonary pneumonitis and fibrosis, radiation-induced pulmonary pneumonitis and fibrosis, hypersensitivity pneumonitis (extrinsic allergic alveolitis) and pneumoconiosis such as silicosis, anthracosis, etc.)
☐ Restrictive lung disease
If checked, specify: _____ ICD code: _____ Date of diagnosis: _____
(Restrictive lung diseases include but are not limited to diaphragm paralysis or paresis, spinal cord injury with respiratory insufficiency, kyphoscoliosis, pectus excavatum, pectus carinatum, traumatic chest wall defect, pneumothorax, hernia, etc., post-surgical residual (lobectomy, pneumonectomy, etc.), chronic pleural effusion or fibrosis)
☐ Sarcoidosis ICD code: _____ Date of diagnosis: _____
☐ Benign or malignant neoplasm or metastases of respiratory system
If checked, specify: _____ ICD code: _____ Date of diagnosis: _____
☐ Pulmonary vascular disease (including pulmonary thromboembolism)
If checked, specify: _____ ICD code: _____ Date of diagnosis: _____
☐ Other, specify: _____

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

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

NOTE: If diagnosed with Sleep Apnea and/or Narcolepsy complete the Sleep Apnea and/or Narcolepsy Questionnaire(s), in lieu of this one.

SECTION II: MEDICAL HISTORY
a. Describe the history (including onset and course) of the Veteran's respiratory condition (brief summary): _____

b. Does the Veteran's respiratory condition require the use of oral or parenteral corticosteroid medications?
☐ Yes ☐ No
If yes, complete the following:

☐ Requires chronic low dose (maintenance) corticosteroids
☐ Requires intermittent courses or bursts of systemic (oral or parenteral) corticosteroids
If checked, indicate number of courses or bursts in past 12 months:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
☐ Requires systemic (oral or parenteral) high dose (therapeutic) corticosteroids for control
☐ Requires daily use of systemic (oral or parenteral) high dose corticosteroids or immuno-suppressive medications
☐ Other, describe: _____

If the Veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the need for corticosteroids or immuno-suppressive medications: _____

c. Does the Veteran's respiratory condition require the use of inhaled medications?
☐ Yes ☐ No
If yes, check all that apply:
☐ Inhalational bronchodilator therapy
If checked, indicate frequency: ☐ Intermittent ☐ Daily
☐ Inhalational anti-inflammatory medication
If checked, indicate frequency: ☐ Intermittent ☐ Daily
☐ Other inhaled medications, describe: _____

If the Veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the need for inhaled medications: _____

d. Does the Veteran's respiratory condition require the use of oral bronchodilators?
☐ Yes ☐ No
If yes, indicate frequency:
☐ Intermittent ☐ Daily

e. Does the Veteran's respiratory condition require the use of antibiotics?
☐ Yes ☐ No
If yes, list antibiotics, dose, frequency and condition for which antibiotics are prescribed: _____

f. Does the Veteran require outpatient oxygen therapy for his or her respiratory condition?
☐ Yes ☐ No
If yes, does the Veteran require continuous oxygen therapy (>17 hours/day)?
☐ Yes ☐ No
If the Veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the requirement for oxygen therapy: _____

SECTION III: Pulmonary conditions
Does the Veteran have any of the following pulmonary conditions?
☐ Yes ☐ No
If no, proceed to Section V.
If yes, check all that apply:
☐ Asthma (If checked, complete # 1 below)
☐ Bronchiectasis (If checked, complete # 2 below)
☐ Sarcoidosis (If checked, complete # 3 below)
☐ Pulmonary vascular disease including pulmonary embolism (If checked, complete # 4 below)
☐ Bacterial lung infection (If checked, complete # 5 below)
☐ Mycotic lung infection (If checked, complete # 6 below)
☐ Pneumothorax (If checked, complete # 7 below)
☐ Gunshot/fragment wound (If checked, complete # 8 below)
☐ Cardiopulmonary complications (If checked, complete # 9 below)
☐ Respiratory failure (If checked, complete # 10 below)

☐ Tumors and neoplasms (If checked, complete # 11 below)
☐ Other pulmonary conditions, pertinent physical findings or scars due to pulmonary conditions __
(If checked, complete # 12 below)

1. Asthma

a. Does the Veteran have a history of asthmatic attacks?
☐ Yes ☐ No

b. Has the Veteran had any asthma attacks or exacerbations in the past 12 months?
☐ Yes ☐ No
If yes, check all that apply:
☐ No asthma attacks in the past 12 months
☐ No asthma exacerbations in the past 12 months
☐ Physician visits for required care of exacerbations
If checked, indicate frequency:
☐ Less frequently than monthly ☐ At least monthly
☐ More than one attack per week
If checked, indicate average number of asthma attacks per week in past 12 months:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
☐ Episodes of respiratory failure
If checked, indicate number of episodes of respiratory failure due to asthma in past 12 months:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

c. Has the Veteran had any physician visits for required care of exacerbations?
☐ Yes ☐ No
If yes, indicate frequency:
☐ Less frequently than monthly
☐ At least monthly

d. Has the Veteran had any episodes of respiratory failure?
☐ Yes ☐ No
If yes, indicate number of episodes of respiratory failure in past 12 months:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

2. Bronchiectasis

a. Indicate any findings, signs and symptoms that are attributable to bronchiectasis:
☐ Productive cough
If checked, indicate frequency and severity of productive cough (check all that apply):
☐ Intermittent
☐ Daily with purulent sputum at times
☐ Daily with blood-tinged sputum at times
☐ Near constant with purulent sputum
☐ Other, describe: _____
☐ Acute infection
If checked, indicate number of infections requiring a prolonged course of antibiotics (lasting 4 to 6 weeks) in the past 12 months
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
☐ Requiring antibiotic usage almost continuously
☐ Anorexia
If checked, describe: _____
☐ Weight loss
If checked, provide baseline weight: _____ and current weight: _____
(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)
☐ Frank hemoptysis
If checked, describe: _____
☐ Other, describe: _____

b. Has the Veteran had any incapacitating episodes of infection due to bronchiectasis?
NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician.
☐ Yes ☐ No
If yes, indicate total duration of incapacitating episodes of infection in past 12 months:
☐ 0 to no more than 2 weeks ☐ 2 to no more than 4 weeks
☐ 4 to no more than 6 weeks ☐ At least 6 weeks or more

3. Sarcoidosis
a. Does the Veteran have any findings, signs or symptoms attributable to sarcoidosis?
☐ Yes ☐ No
If yes, check all that apply:
☐ No physiologic impairment
☐ No symptoms
☐ Persistent symptoms
If checked, describe: _____
☐ Chronic hilar adenopathy
☐ Stable lung infiltrates
☐ Pulmonary involvement
☐ Progressive pulmonary disease
If checked, describe: _____
☐ Cardiac involvement with congestive heart failure
☐ Fever
If checked, describe: _____
☐ Night sweats
If checked, describe: _____
☐ Weight loss
If checked, provide baseline weight: _____ and current weight: _____
(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)
☐ Other, describe: _____

b. Indicate stage diagnosed by x-ray findings:
☐ Stage 1: Bihilar lymphadenopathy
☐ Stage 2: Bihilar lymphadenopathy and reticulonodular infiltrates
☐ Stage 3: Bilateral pulmonary infiltrates
☐ Stage 4: Fibrocystic sarcoidosis typically with upward hilar retraction, cystic and bullous changes

c. Does the Veteran have ophthalmologic, renal, cardiac, neurologic, or other organ system involvement due to sarcoidosis?
☐ Yes ☐ No
If yes, also complete appropriate additional Questionnaires.

4. Pulmonary vascular disease including pulmonary embolism
Select the statement(s) that best describe the Veteran's pulmonary vascular disease or pulmonary embolism condition (check all that apply):
☐ Asymptomatic, following resolution of pulmonary thromboembolism
☐ Symptomatic, following resolution of acute pulmonary embolism
☐ Chronic pulmonary thromboembolism requiring anticoagulant therapy
☐ Following inferior vena cava surgery
☐ Chronic pulmonary thromboembolism
☐ Pulmonary hypertension secondary to other obstructive disease of pulmonary arteries or veins with evidence of right ventricular hypertrophy or cor pulmonale
☐ Other, describe: _____

5. Bacterial lung infection

a. Indicate current status of the Veteran's bacterial infection of the lung (including actinomycosis, nocardiosis and chronic lung abscess):

☐ Active ☐ Inactive

b. Does the Veteran have any findings, signs and symptoms attributable to a bacterial infection of the lung or chronic lung abscess?

☐ Yes ☐ No

If yes, check all that apply:

- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss
  - If checked, provide baseline weight: _____ and current weight: _____
  - (For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)
- ☐ Hemoptysis
- ☐ Other, describe: _____

6. Mycotic lung diseases

Indicate status of mycotic lung disease (including histoplasmosis of lung, coccidioidomycosis, blastomycosis, cryptococcosis, aspergillosis, or mucormycosis) (check all that apply):

- ☐ Chronic pulmonary mycosis
- ☐ Healed and inactive mycotic lesions
- ☐ No symptoms
- ☐ Occasional productive cough
- ☐ Occasional minor hemoptysis
- ☐ Requires suppressive therapy
- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss
  - If checked, provide baseline weight: _____ and current weight: _____
  - (For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)
- ☐ Massive hemoptysis
- ☐ Other, describe: _____

7. Pneumothorax

Indicate the type of pneumothorax, treatment and residual conditions, if any (check all that apply):

- ☐ Spontaneous total pneumothorax
- ☐ Spontaneous partial pneumothorax
- ☐ Traumatic total pneumothorax
- ☐ Traumatic partial pneumothorax
- ☐ Resulting in hospitalization
  - If checked, provide date of hospital admission_____ and date of discharge:_____
- ☐ Resulting in residual conditions
  - If checked, describe: _____
- ☐ Other, describe: _____

8. Gunshot/fragment wound

Select the statement(s) that best describe the Veteran's gunshot or fragment wound of the pleural cavity and residuals, if any (check all that apply)

- ☐ Bullet or missile retained in lung
- ☐ Pain or discomfort on exertion
- ☐ Scattered rales
- ☐ Some limitation of excursion of diaphragm or of lower chest expansion
- ☐ Other, describe: _____

NOTE: If any muscles (other than those which control respiration) are affected by this injury, also complete a

Muscle Injuries Questionnaire**.**

9. Cardiopulmonary complications

a. Does the Veteran's respiratory condition result in cardiopulmonary complications such as cor pulmonale, right ventricular hypertrophy or pulmonary hypertension?

☐ Yes ☐ No

If yes, check all that apply:

- ☐ Cor pulmonale (right heart failure)
- ☐ Right ventricular hypertrophy
- ☐ Pulmonary hypertension (shown by echocardiogram or cardiac catheterization; report test results in Diagnostic testing section)
- ☐ Other, describe: _____

b. If the Veteran has more than one respiratory condition, indicate which condition is predominantly responsible for the cardiopulmonary complications: _____

10. Respiratory failure

Provide dates and describe the Veteran's episodes of acute respiratory failure: _____

If the Veteran has more than one respiratory condition, indicate which condition is predominantly responsible for the episodes of respiratory failure: _____

11. Tumors and neoplasms

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

☐ Yes ☐ No

If yes, complete the following section:

a. Is the neoplasm:

☐ Benign ☐ Malignant

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

☐ Yes ☐ No; watchful waiting

If yes, indicate type of treatment (check all that apply):

- ☐ Treatment completed; currently in watchful waiting status
- ☐ Surgery
  - If checked, describe: _____
  - Date(s) of surgery: _____
- ☐ Radiation therapy
  - Date of most recent treatment: _____
  - Date of completion of treatment or anticipated date of completion: _____
- ☐ Antineoplastic chemotherapy
  - Date of most recent treatment: _____
  - Date of completion of treatment or anticipated date of completion: _____ _____
- ☐ Other therapeutic procedure
  - If checked, describe procedure: _____
  - Date of most recent procedure: _____
- ☐ Other therapeutic treatment
  - If checked, describe treatment: _____
  - Date of completion of treatment or anticipated date of completion: _____

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

☐ Yes ☐ No

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

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

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

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

☐ Yes ☐ No

If yes, describe (brief summary): _____

SECTION IV: Diagnostic testing

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

a. Have imaging studies or procedures been performed?

☐ Yes ☐ No

If yes, check all that apply:

- ☐ Chest x-ray Date: _____ Results: _____
- ☐ Magnetic resonance imaging (MRI) Date: _____ Results: _____
- ☐ Computed tomography (CT) Date: _____ Results: _____
- ☐ High resolution computed tomography to evaluate interstitial lung disease such as asbestosis (HRCT) Date: _____ Results: _____
- ☐ Bronchoscopy Date: _____ Results: _____
- ☐ Biopsy Date: _____ Results: _____
- ☐ Other: _____ Date: _____ Results: _____

b. Has pulmonary function testing (PFT) been performed?

☐ Yes ☐ No

If yes, do PFT results reported below reflect the Veteran's current pulmonary function?

☐ Yes ☐ No

c. Most respiratory conditions will require pulmonary function testing, since the results of such testing represent a major basis of their evaluation. However, pulmonary function testing is not required in all instances. If PFTs have not been completed, provide reason:

- ☐ Veteran requires outpatient oxygen therapy
- ☐ Veteran has had 1 or more episodes of acute respiratory failure
- ☐ Veteran has been diagnosed with cor pulmonale, right ventricular hypertrophy or pulmonary hypertension
- ☐ Veteran has had exercise capacity testing and results are 20 ml/kg/min or less
- ☐ Other, describe: _____

d. PFT results

Date: _____

Pre-bronchodilator:		Post-bronchodilator, if indicated:	
FEV-1:	_____% predicted	FEV-1:	_____% predicted
FVC:	_____% predicted	FVC:	_____ % predicted
FEV-1/FVC:	_____ %	FEV-1/FVC:	_____ %
DLCO:	_____% predicted	DLCO:	_____ % predicted

e. Which test result most accurately reflects the Veteran's current pulmonary function?

☐ FEV-1%
☐ FEV-1/FVC%
☐ FVC%
☐ DLCO

f. If post-bronchodilator testing has not been completed, provide reason:
☐ Pre-bronchodilator results are normal
☐ Not indicated for Veteran's condition
☐ Not indicated in Veteran's particular case
If checked, provide reason: _____
☐ Other, describe: _____

g. If diffusion capacity of the lung for carbon monoxide by the single breath method (DLCO) testing has not been completed, provide reason:
☐ Not indicated for Veteran's condition
☐ Not indicated in Veteran's particular case
☐ Not valid for Veteran's particular case
☐ Other, describe: _____

h. Does the Veteran have multiple respiratory conditions?
☐ Yes ☐ No
If yes, list conditions and indicate which condition is predominantly responsible for the limitation in pulmonary function, if any limitation is present: _____

i. Has exercise capacity testing been performed?
☐ Yes ☐ No
If yes, complete the following:
☐ Maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation)
☐ Maximum oxygen consumption of 15–20 ml/kg/min (with cardiorespiratory limit)

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

SECTION V: Functional impact and remarks
1. Does the Veteran's respiratory condition impact his or her ability to work?
☐ Yes ☐ No
If yes, describe impact of each of the Veteran's respiratory conditions, providing one or more examples: ____

2. Remarks, if any: _____

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

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

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

Name of patient/Veteran: _____SSN: _____

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

SECTION I
1. Diagnosis
Does the Veteran now have or has he/she ever had a traumatic brain injury (TBI) or any residuals of a TBI?
☐ Yes ☐ No

If yes, select the Veteran's condition (check all that apply):
☐ Traumatic brain injury (TBI) ICD code: _____ Date of diagnosis: _____
☐ Other diagnosed residuals attributable to TBI, specify:

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

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

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

Other diagnosis #4: _____
ICD code: _____
Date of diagnosis: _____

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

2. Medical history
a. Describe the history (including onset and course) of the Veteran's TBI and residuals attributable to TBI (brief summary): _____

b. Does the Veteran's treatment plan include taking continuous medication for the diagnosed condition?
☐ Yes ☐ No
If yes, list only those medications used for the diagnosed condition: _____

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

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

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

1. Memory, attention, concentration, executive functions

☐ No complaints of impairment of memory, attention, concentration, or executive functions
☐ A complaint of mild memory loss (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing
☐ Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment
☐ Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment
☐ Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment

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

2. Judgment
☐ Normal
☐ Mildly impaired judgment. For complex or unfamiliar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision
☐ Moderately impaired judgment. For complex or unfamiliar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, although has little difficulty with simple decisions
☐ Moderately severely impaired judgment. For even routine and familiar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision
☐ Severely impaired judgment. For even routine and familiar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision. For example, unable to determine appropriate clothing for current weather conditions or judge when to avoid dangerous situations or activities.

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

3. Social interaction
☐ Social interaction is routinely appropriate
☐ Social interaction is occasionally inappropriate
☐ Social interaction is frequently inappropriate
☐ Social interaction is inappropriate most or all of the time

If the Veteran's social interaction is not routinely appropriate, describe (brief summary): _____

4. Orientation
☐ Always oriented to person, time, place, and situation
☐ Occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation
☐ Occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation
☐ Often disoriented to two or more of the four aspects (person, time, place, situation) of orientation
☐ Consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation

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

5. Motor activity (with intact motor and sensory system)
☐ Motor activity normal
☐ Motor activity is normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function)
☐ Motor activity is mildly decreased or with moderate slowing due to apraxia
☐ Motor activity moderately decreased due to apraxia
☐ Motor activity severely decreased due to apraxia

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

6. Visual spatial orientation

☐ Normal
☐ Mildly impaired. Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system)
☐ Moderately impaired. Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS (global positioning system)
☐ Moderately severely impaired. Gets lost even in familiar surroundings, unable to use assistive devices such as GPS (global positioning system)
☐ Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment

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

7. Subjective symptoms

☐ No subjective symptoms
☐ Subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples are: mild or occasional headaches, mild anxiety
☐ Three or more subjective symptoms that mildly interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light
☐ Three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days

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

8. Neurobehavioral effects

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

☐ No neurobehavioral effects
☐ One or more neurobehavioral effects that do not interfere with workplace interaction or social interaction.
☐ One or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them
☐ One or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them
☐ One or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction, or both on most days or that occasionally require supervision for safety of self or others

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

9. Communication

☐ Able to communicate by spoken and written language (expressive communication) and to comprehend spoken and written language.
☐ Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas.

☐ Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than occasionally but less than half of the time. Can generally communicate complex ideas
☐ Inability to communicate either by spoken language, written language, or both, at least half of the time but not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs
☐ Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both. Unable to communicate basic needs

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

10. Consciousness

☐ Normal
☐ Persistent altered state of consciousness, such as vegetative state, minimally responsive state, coma.
If checked, describe altered state of consciousness (brief summary): _____

SECTION III

1. Residuals

Does the Veteran have any subjective symptoms or any mental, physical or neurological conditions or residuals attributable to a TBI (such as migraine headaches or Meniere's disease)?
☐ Yes ☐ No
If yes, check all that apply:

☐ Motor dysfunction
If checked, ALSO complete specific Joint or Spine Questionnaire for the affected joint or spinal area.
☐ Sensory dysfunction
If checked, ALSO complete appropriate Cranial or Peripheral Nerve Questionnaire.
☐ Hearing loss and/or tinnitus
If checked, ALSO complete a Hearing Loss and Tinnitus Questionnaire.
☐ Visual impairment
If checked, ALSO complete an Eye Questionnaire.
☐ Alteration of sense of smell or taste
If checked, ALSO complete a Loss of Sense of Smell and Taste Questionnaire.
☐ Seizures
If checked, ALSO complete a Seizure Disorder Questionnaire.
☐ Gait, coordination, and balance
If checked, ALSO complete appropriate Questionnaire for underlying cause of gait and balance disturbance, such as Ear Questionnaire.
☐ Speech (including aphasia and dysarthria)
If checked, ALSO complete appropriate Questionnaire.
☐ Neurogenic bladder
If checked, ALSO complete appropriate Genitourinary Questionnaire.
☐ Neurogenic bowel
If checked, ALSO complete appropriate Intestines Questionnaire.
☐ Cranial nerve dysfunction
If checked, ALSO complete a Cranial Nerves Questionnaire.
☐ Skin disorders
If checked, ALSO complete a Skin and/or Scars Questionnaire.
☐ Endocrine dysfunction
If checked, ALSO complete an Endocrine Conditions Questionnaire.
☐ Erectile dysfunction
If checked, ALSO complete Male Reproductive Conditions Questionnaire.
☐ Headaches, including Migraine headaches
If checked, ALSO complete a Headache Questionnaire.
☐ Meniere's disease

If checked, ALSO complete an Ear Conditions Questionnaire.

☐ Mental disorder (including emotional, behavioral, or cognitive)

If checked, ALSO complete Mental Disorders or PTSD Questionnaire.

☐ Other, describe: _____

If checked, ALSO complete appropriate Questionnaire.

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

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

☐ Yes ☐ No

If yes, describe (brief summary): _____

3. Diagnostic testing

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

a. Has neuropsychological testing been performed?

☐ Yes ☐ No

If yes, provide date: _____

Results: _____

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

☐ Yes ☐ No

If yes, check all that apply:

☐ Magnetic resonance imaging (MRI)

Date: _____ Results: _____

☐ Computed tomography (CT)

Date: _____ Results: _____

☐ EEG

Date: _____ Results: _____

☐ Other, describe: _____

Date: _____ Results: _____

c. Has laboratory testing been performed?

☐ Yes ☐ No

If yes, specify tests: _____ Date: _____ Results: _____

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

☐ Yes ☐ No

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

4. Functional impact

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

☐ Yes ☐ No

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

5. Remarks, if any: _____

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

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

6.20. DBQ Seizure Disorders (Epilepsy)

Name of patient/Veteran: _____ SSN: _____

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

1. Diagnosis

Does the Veteran have or has he/she ever been diagnosed with a seizure disorder (epilepsy)?
☐ Yes ☐ No

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

☐ Tonic-clonic seizures or grand mal (generalized convulsive seizures)
ICD code: _____ Date of diagnosis: _____

☐ Absence seizures or petit mal or atonic seizures (generalized non-convulsive seizures)
ICD code: _____ Date of diagnosis: _____

☐ Jacksonian (simple partial seizures) ICD code: _____ Date of diagnosis: _____

☐ Focal motor ICD code: _____ Date of diagnosis: _____

☐ Focal sensory ICD code: _____ Date of diagnosis: _____

☐ Diencephalic epilepsy ICD code: _____ Date of diagnosis: _____

☐ Psychomotor epilepsy (complex partial seizures, temporal lobe seizures)
ICD code: _____ Date of diagnosis: _____

☐ Other, specify:
Other diagnosis #1: _____
ICD code: _____
Date of diagnosis: _____

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

If there are additional diagnoses that pertain to seizure disorders (epilepsy), list using above format: ___

2. Medical history

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

b. Is continuous medication required for control of epilepsy or seizure activity?
☐ Yes ☐ No
If yes, list only those medications required for the Veteran's epilepsy or seizure activity: _____

c. Has the Veteran had any other treatment (such as surgery) for epilepsy or seizure activity?
☐ Yes ☐ No
If yes, describe: _____

d. Has the diagnosis of a seizure disorder been confirmed?
☐ Yes ☐ No
If yes, describe: _____

e. Has the Veteran had a witnessed seizure?
☐ Yes ☐ No
If yes, describe, including relationship of witnesses to Veteran: _____

3. Findings, signs and symptoms

Does the Veteran have or has he or she had any findings, signs or symptoms attributable to seizure disorder (epilepsy) activity?

☐ Yes ☐ No

If yes, check all that apply:

- ☐ Generalized tonic-clonic convulsions
- ☐ Episodes of unconsciousness
- ☐ Brief interruption in consciousness or conscious control
- ☐ Episodes of staring
- ☐ Episodes of rhythmic blinking of the eyes
- ☐ Episodes of nodding of the head
- ☐ Episodes of sudden jerking movement of the arms, trunk or head (myoclonic type)
- ☐ Episodes of sudden loss of postural control (akinetic type)
- ☐ Episodes of complete or partial loss of use of one or more extremities
- ☐ Episodes of random motor movements
- ☐ Episodes of psychotic manifestations
- ☐ Episodes of hallucinations
- ☐ Episodes of perceptual illusions
- ☐ Episodes of abnormalities of thinking
- ☐ Episodes of abnormalities of memory
- ☐ Episodes of abnormalities of mood
- ☐ Episodes of autonomic disturbances
- ☐ Episodes of speech disturbances
- ☐ Episodes of impairment of vision
- ☐ Episodes of disturbances of gait
- ☐ Episodes of tremors
- ☐ Episodes of visceral manifestations
- ☐ Residuals of injury during seizure, describe: _____
- ☐ Other, describe: _____

4. Type and frequency of seizure activity

Does the Veteran have or has he or she ever had any type of seizure activity, including major, minor, petit mal or psychomotor seizure activity?

☐ Yes ☐ No

If yes, complete the following:

a. Provide approximate date of first seizure activity: _____

Date of most recent seizure activity: _____

b. Has the Veteran ever had minor seizures (a minor seizure is characterized by a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head ("pure" petit mal) or sudden jerking movements of the arms, trunk or head (myoclonic type) or sudden loss of postural control (akinetic type))?

☐ Yes ☐ No

If yes, complete the following:

Number of minor seizures over past 6 months:

- ☐ 0-1
- ☐ 2 or more

If 2 or more over the past 6 months, indicate the average frequency of minor seizures:

- ☐ 0-4 per week
- ☐ 5-8 per week
- ☐ 9-10 per week
- ☐ More than 10 per week

c. Has the Veteran ever had major seizures (a major seizure is characterized by the generalized tonic-clonic convulsion with unconsciousness)?

☐ Yes ☐ No
If yes, complete the following:
Number of major seizures:
☐ None in past 2 years
☐ At least 1 in past 2 years
☐ At least 2 in past year
Average frequency of major seizures:
☐ Less than 1 in past 6 months
☐ At least 1 in past 6 months
☐ At least 1 in 4 months over past year
☐ At least 1 in 3 months over past year
☐ At least 1 per month over past year

d. Has the Veteran ever had minor psychomotor seizures (minor psychomotor seizures are characterized by brief transient episodes of random motor movements, hallucinations, perceptual illusions, abnormalities of thinking, memory or mood, or autonomic disturbances)?
☐ Yes ☐ No
If yes, complete the following:
Number of minor psychomotor seizures over past 6 months:
☐ 0-1
☐ 2 or more
If 2 or more over the past 6 months, indicate the average frequency of minor psychomotor seizures:
☐ 0-4 per week
☐ 5-8 per week
☐ 9-10 per week
☐ More than 10 per week

e. Has the Veteran ever had major psychomotor seizures (major psychomotor seizures are characterized by automatic states and/or generalized convulsions with unconsciousness)?
☐ Yes ☐ No
If yes, complete the following:
Number of major psychomotor seizures:
☐ None in past 2 years
☐ At least 1 in past 2 years
☐ At least 2 in past year
Average frequency of major psychomotor seizures:
☐ Less than 1 in past 6 months
☐ At least 1 in past 6 months
☐ At least 1 in 4 months over past year
☐ At least 1 in 3 months over past year
☐ At least 1 per month over past year

f. Has the Veteran ever had a nonpsychotic organic brain syndrome associated with epilepsy?
☐ Yes ☐ No
If yes, describe: _____

g. Has the Veteran ever had a psychotic disorder, psychoneurotic disorder, or personality disorder associated with epilepsy?
☐ Yes ☐ No
If yes, the appropriate Mental Disorder Questionnaire must ALSO be completed.

5. Other pertinent physical findings, scars, complications, conditions, signs and/or symptoms
a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?
☐ Yes ☐ No

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

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

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

☐ Yes ☐ No

If yes, describe (brief summary): _____

6. Diagnostic testing

NOTE: If diagnostic test results are in the medical record and reflect the Veteran's current seizure disorder (epilepsy), repeat testing is not required.

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

☐ Yes ☐ No

If yes, check all that apply:

☐ Magnetic resonance imaging (MRI) Date: _____ Results: _____
☐ Computed tomography (CT) Date: _____ Results: _____
☐ Cerebrospinal fluid (CSF) examination Date: _____ Results: _____
☐ Electroencephalography (EEG) Date: _____ Results: _____
☐ Neuropsychologic testing Date: _____ Results: _____
☐ Other, describe: _____ Date: _____ Results: _____

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

☐ Yes ☐ No

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

7. Functional impact

Does the Veteran's epilepsy or seizure (epilepsy) disorder impact his or her ability to work?

☐ Yes ☐ No

If yes, describe the impact of the Veteran's seizure (epilepsy) disorder, providing one or more examples:

_____

8. Remarks, if any: _____

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

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

6.21. DBQ Sinusitis/Rhinitis and other Conditions of the Nose, Throat, Larynx and Pharynx

Name of patient/Veteran: _____ SSN: _____

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

1. Diagnosis:

Does the Veteran now have or has he/she ever been diagnosed with a sinus, nose, throat, larynx, or pharynx condition?

☐ Yes ☐ No

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

- ☐ Chronic sinusitis ICD code: _____ Date of diagnosis: _____
- ☐ Allergic rhinitis ICD code: _____ Date of diagnosis: _____
- ☐ Vasomotor rhinitis ICD code: _____ Date of diagnosis: _____
- ☐ Bacterial rhinitis ICD code: _____ Date of diagnosis: _____
- ☐ Granulomatous rhinitis ICD code: _____Date of diagnosis: _____
- ☐ Chronic laryngitis ICD code: _____Date of diagnosis: _____
- ☐ Laryngectomy ICD code: _____ Date of diagnosis: _____
- ☐ Laryngeal stenosis ICD code: _____ Date of diagnosis: _____
- ☐ Aphonia ICD code: _____ Date of diagnosis: _____
- ☐ Pharyngeal injury, describe:
  ICD code: _____ Date of diagnosis: _____
- ☐ Deviated nasal septum (traumatic)
  ICD code: _____ Date of diagnosis: _____
- ☐ Anatomical loss of part of nose: Complete Scars DBQ in lieu of this Questionnaire.
- ☐ Benign or malignant neoplasm of sinus, nose, throat, larynx or pharynx
  ICD code: _____ Date of diagnosis: _____
- ☐ Other, specify:

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

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

If there are additional diagnoses that pertain to the sinuses, nose, throat, larynx, or pharynx conditions, list using above format: _____

2. Medical history

a. Describe the history (including onset and course) of the Veteran's sinus, nose, throat, larynx, or pharynx condition: _____

b. Is continuous medication required for control of a sinus, nose, throat, larynx, or pharynx condition?

☐ Yes ☐ No

If yes, list only those medications required for the Veteran's sinus, nose, throat, larynx, or pharynx condition:

_____

3. Sinusitis

Does the Veteran have chronic sinusitis?

☐ Yes ☐ No
If yes, complete the following:

a. Indicate the sinuses/type of sinusitis currently affected by the Veteran's chronic sinusitis (check all that apply):
☐ None ☐ Maxillary ☐ Frontal ☐ Ethmoid ☐ Sphenoid ☐ Pansinusitis

b. Does the Veteran currently have any findings, signs or symptoms attributable to chronic sinusitis?
☐ Yes ☐ No
If yes, check all that apply:
- ☐ Chronic sinusitis detected only by imaging studies (see Diagnostic testing section)
- ☐ Episodes of sinusitis
- ☐ Near constant sinusitis
  If checked, describe frequency: _____
- ☐ Headaches
- ☐ Pain and tenderness of affected sinus
- ☐ Purulent discharge or crusting

For all checked conditions or for any other conditions, describe: _____

c. Has the Veteran had NON-INCAPACITATING episodes of sinusitis characterized by headaches, pain and purulent discharge or crusting in the past 12 months?
☐ Yes ☐ No
If yes, provide the total number of non-incapacitating episodes over the past 12 months:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

d. Has the Veteran had INCAPACITATING episodes of sinusitis requiring prolonged (4 to 6 weeks) of antibiotics treatment in the past 12 months?
NOTE: For VA purposes, an incapacitating episode of sinusitis means one that requires bed rest and treatment prescribed by a physician.
☐ Yes ☐ No
If yes, provide the total number of incapacitating episodes of sinusitis requiring prolonged (4 to 6 weeks) of antibiotic treatment over past 12 months:
☐ 1 ☐ 2 ☐ 3 or more

e. Has the Veteran had sinus surgery?
☐ Yes ☐ No
If yes, specify type of surgery:
☐ Radical ☐Endoscopic ☐ Other: _____
Date(s) of surgery (if repeated sinus surgery, provide all dates of surgery): _____
If Veteran has had radical sinus surgery, did chronic osteomyelitis follow the surgery?
☐ Yes ☐ No
If yes, complete Osteomyelitis Questionnaire

4. Rhinitis
Does the Veteran have allergic, vasomotor, bacterial or granulomatous rhinitis?
☐ Yes ☐ No
If yes, complete the following:

a. Is there greater than 50% obstruction of the nasal passage on both sides due to rhinitis?
☐ Yes ☐ No

b. Is there complete obstruction on one side due to rhinitis?
☐ Yes ☐ No

c. Is there permanent hypertrophy of the nasal turbinates?
☐ Yes ☐ No

d. Are there nasal polyps?
☐ Yes ☐ No

e. Does the Veteran have any of the following granulomatous conditions?
☐ Yes ☐ No
If yes, check all that apply:
☐ Granulomatous rhinitis ☐ Rhinoscleroma ☐ Wegener's granulomatosis ☐ Lethal midline granuloma
☐ Other granulomatous infection, describe: _____

5. Larynx and pharynx conditions
Does the Veteran have chronic laryngitis, laryngectomy, aphonia, laryngeal stenosis, pharyngeal injury or any other pharyngeal conditions?
☐ Yes ☐ No
If yes, complete the following:

a. Does the Veteran have any of the following symptoms due to chronic laryngitis?
☐ Yes ☐ No
If yes, check all that apply:
☐ Hoarseness
If checked, describe frequency: _____
☐ Inflammation of vocal cords or mucous membrane
☐ Thickening or nodules of vocal cords
☐ Submucous infiltration of vocal cords
☐ Vocal cord polyps
☐ Other, describe: _____

b. Has the Veteran had a laryngectomy?
☐ Yes ☐ No
If yes, specify:
☐ Total laryngectomy
☐ Partial laryngectomy
If checked, does the Veteran have any residuals of the partial laryngectomy?
☐ Yes ☐ No
If yes, describe: _____

c. Does the Veteran have laryngeal stenosis, including residuals of laryngeal trauma (unilateral or bilateral)?
☐ Yes ☐ No
If yes, assess for upper airway obstruction with pulmonary function testing, to include Flow-Volume Loop, and provide results in Diagnostic testing section.

d. Does the Veteran have complete organic aphonia?
☐ Yes ☐ No
If yes, check all that apply:

☐ Constant inability to speak above a whisper
☐ Constant inability to communicate by speech
☐ Other, describe: _____

e. Does veteran have incomplete organic aphonia?
☐ Yes ☐ No
If yes, check all that apply:
☐ Hoarseness
If checked, describe frequency: _____
☐ Inflammation of vocal cords or mucous membrane
☐ Thickening or nodules of vocal cords

☐ Submucous infiltration of vocal cords
☐ Vocal cord polyps
☐ Other, describe: _____

f. Has the Veteran had a permanent tracheostomy?
☐ Yes ☐ No

g. Has the Veteran had an injury to the pharynx?
☐ Yes ☐ No
If yes, check all findings, signs and symptoms that apply:
☐ Stricture or obstruction of the pharynx or nasopharynx
☐ Absence of the soft palate secondary to trauma
☐ Absence of the soft palate secondary to chemical burn
☐ Absence of the soft palate secondary to granulomatous disease
☐ Paralysis of the soft palate with swallowing difficulty (nasal regurgitation) and speech impairment
☐ Other, describe: _____

6. Deviated nasal septum (traumatic)
Does the Veteran have a deviated nasal septum due to trauma?
☐ Yes ☐ No
If yes, complete the following:

a. Is there at least 50% obstruction of the nasal passage on both sides due to traumatic septal deviation?
☐ Yes ☐ No

b. Is there complete obstruction on one side due to traumatic septal deviation?
☐ Yes ☐ No

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

a. Is the neoplasm:
☐ Benign ☐ Malignant

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

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

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

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

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

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

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

9. Diagnostic testing

NOTE: If diagnostic test results are in the medical record and reflect the Veteran's current sinus, nose, throat, larynx or pharynx condition, repeat testing is not required.

a. Have imaging studies of the sinuses or other areas been performed?
☐ Yes ☐ No
If yes, check all that apply:
☐ Magnetic resonance imaging (MRI) Date: _____ Results: _____
☐ Computed tomography (CT) Date: _____ Results: _____
☐ X-rays: _____ Date: _____ Results: _____
☐ Other: _____ Date: _____ Results: _____

b. Has endoscopy been performed?
☐ Yes ☐ No
If yes, complete the following:
If yes, check all that apply:
☐ Nasal endoscopy Date: _____ Results: _____
☐ Laryngeal endoscopy Date: _____ Results: _____
☐ Other endoscopy Date: _____ Results: _____

c. Has the Veteran had a biopsy of the larynx or pharynx?
☐ Yes ☐ No
If yes, complete the following:
Site of biopsy: _____ Date: _____Results:
☐ Benign ☐ Pre-malignant ☐ Malignant
Describe results: _____

d. Has the Veteran had pulmonary function testing to assess for upper airway obstruction due to laryngeal stenosis?
☐ Yes ☐ No
If yes, indicate results:
☐ FEV-1 of 71 to 80% predicted
☐ FEV-1 of 56 to 70% predicted

☐ FEV-1 of 40 to 55% predicted
☐ FEV-1 less than 40% predicted
Is the Flow-Volume Loop compatible with upper airway obstruction?
☐ Yes ☐ No

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

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

11. Remarks, if any: _____

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

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

6.22.DBQ Systemic Lupus Erythematosus (SLE) and other Autoimmune Diseases (other than HIV and Diabetes Mellitus Type I)

Name of patient/Veteran: _____ SSN: _____

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

1. Diagnosis

Does the Veteran have or has he/she had a systemic or localized autoimmune disease, including systemic lupus erythematosus (SLE)?

☐ Yes ☐ No

If no, provide rationale (e.g., Veteran does not currently have any known autoimmune diseases, including SLE. Provide substantiating information including diagnostic test results, if available, to document the absence of these disorders):

_____

If yes, select the Veteran's condition:

- ☐ Autoimmune polyglandular syndrome
  ICD code: _____ Date of diagnosis: _____
  If this condition affects multiple endocrine glands, ALSO complete appropriate Questionnaire(s) for those conditions
- ☐ Discoid lupus erythematosus ICD code: _____ Date of diagnosis: _____
- ☐ Familial Mediterranean fever ICD code: _____ Date of diagnosis: _____
- ☐ Goodpasture's syndrome ICD code: _____ Date of diagnosis: _____
  If this condition affects the lungs or kidneys, ALSO complete appropriate Questionnaire(s) for those conditions.
- ☐ Guillain-Barre syndrome ICD code: _____ Date of diagnosis: _____
  If this condition affects the nervous system, ALSO complete appropriate Questionnaire(s) for those conditions
- ☐ Immunodeficiency with hyper-IgM ICD code: _____ Date of diagnosis: _____
- ☐ Polymyalgia rheumatica ICD code: _____ Date of diagnosis: _____
  If this condition affects large muscle groups, ALSO complete appropriate Questionnaire(s) for those conditions
- ☐ Rheumatoid arthritis (RA) and Juvenile RA (JRA)
  ICD code: _____ Date of diagnosis: _____
  If this condition affects the joints, lungs or skin, ALSO complete appropriate Questionnaire(s) for those conditions
- ☐ Scleroderma ICD code: _____ Date of diagnosis: _____
  If this condition affects the lungs, skin or intestines, ALSO complete appropriate Questionnaire(s) for those conditions.
- ☐ Severe combined immunodeficiency ICD code: _____ Date of diagnosis: _____
- ☐ Sjögren's syndrome ICD code: _____ Date of diagnosis: _____
  If this condition affects the salivary glands, lacrimal glands, joints or kidneys, ALSO complete appropriate Questionnaire(s) for those conditions.
- ☐ Subacute cutaneous lupus erythematosus
  ICD code: _____ Date of diagnosis: _____
- ☐ Systemic lupus erythematosus ICD code: _____ Date of diagnosis: _____
- ☐ Temporal arteritis/Giant cell arteritis ICD code: _____ Date of diagnosis: _____
- ☐ Wegener's granulomatosis ICD code: _____ Date of diagnosis: _____
  If this condition affects the blood vessels, sinuses, lungs or kidneys, ALSO complete appropriate Questionnaire(s).
- ☐ Other, specify:
  Other diagnosis #1: _____
  ICD code: _____
  Date of diagnosis: _____

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

If there are additional diagnoses that pertain to autoimmune diseases, list using above format:
_____

For all checked diagnoses, ALSO complete additional DBQs as appropriate to fully described effects of the condition.

If the Veteran has HIV, complete the HIV Questionnaire in lieu of this Questionnaire.
If the Veteran has Diabetes Mellitus Type I, complete the Diabetes Questionnaire in lieu of this Questionnaire.

2. Medical history
a. Describe the history (including onset and course) of the Veteran's autoimmune disease, including SLE (brief summary):
_____

b. Over the past 12 months, has the Veteran's treatment plan included oral or topical medications for any autoimmune disease or autoimmune disorder-related skin condition, including systemic, cutaneous or discoid lupus?

☐ Yes ☐ No

If yes, check all that apply:

☐ Oral corticosteroids

If checked, list medications: _____

Specify condition medication used for: _____

Total duration of medication use in past 12 months:

☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Other immunosuppressive medications

If checked, list medications: _____

Specify condition medication used for: _____

Total duration of medication use in past 12 months:

☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Immunosuppressive retinoids

If checked, list medication(s): _____

Specify condition medication used for: _____

Total duration of medication use in past 12 months:

☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Topical corticosteroids

If checked, list medications: _____

Specify condition medication used for: _____

Total duration of topical corticosteroid use in past 12 months:

☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Other oral or topical medications used for an autoimmune condition

If checked, list medications: _____

Specify condition medication used for: _____

Total duration of other oral medication use in past 12 months:

☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

c. Indicate status of the Veteran's autoimmune disease, including SLE:

☐ Acute ☐ Chronic ☐ Other, describe: _____

d. Does the Veteran have exacerbations of an autoimmune disease, including SLE?

☐ Yes ☐ No

If yes, describe exacerbations (brief summary): _____

Indicate average frequency of exacerbations per year:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ More than 3 exacerbations per year

Indicate average duration of symptoms during each exacerbation:

☐ Lasting less than one week
☐ Lasting a week or more
☐ Other, describe: _____

e. Does the Veteran's autoimmune disease, including SLE, currently produce severe impairment of health?

☐ Yes ☐ No

If checked, describe the severe impairment of health: _____

3. Cutaneous manifestations

Does the Veteran have any cutaneous manifestations of an autoimmune disease, including systemic, cutaneous or discoid lupus erythematosus?

☐ Yes ☐ No

If yes, complete the following section:

a. Specify the cutaneous manifestations (check all that apply):

☐ Discoid lupus erythematosus
☐ Subacute cutaneous lupus erythematosus
☐ Other, describe: _____

b. Indicate areas affected by cutaneous manifestations (check all that apply):

☐ Malar rash over bridge of nose and bilateral cheeks, sparing nasolabial folds
☐ Cheeks
If checked, specify: ☐ Right ☐ Left ☐ Both
☐ Ears
If checked, specify: ☐ Right ☐ Left ☐ Both
☐ Nose
☐ Chin
☐ Lips and mouth, causing ulcers and scaling
☐ Hands
☐ Feet
☐ Scalp, causing scarring alopecia
☐ Other body areas, specify location: _____

For all checked areas, describe cutaneous manifestations: _____

c. Indicate approximate TOTAL body area affected by cutaneous manifestations of an autoimmune disease on current examination:

☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%

d. Indicate approximate total EXPOSED body area (face, neck and hands) affected by cutaneous manifestations of an autoimmune disease on current examination:

☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ > 40%

e. Do the cutaneous manifestations of the autoimmune disease cause scarring alopecia?
☐ Yes ☐ No
If yes, indicate percent of scalp affected:
☐ < 20 % ☐ 20 to 40% ☐ > 40%

f. Do the cutaneous manifestations of the autoimmune disease cause scarring (including surgical scars related to the condition, if any) that is unstable, painful, causes disfigurement of the head, face or neck, or has a total area of all related scars greater than 39 square cm (6 square inches)?
☐ Yes ☐ No
If yes, ALSO complete a Scars Questionnaire.

4. Findings, signs and symptoms
Does the Veteran have any findings, signs or symptoms (other than cutaneous manifestations) attributable to an autoimmune disease, including SLE?

☐ Yes ☐ No

If yes, complete the following section:

a. Has the Veteran had any symptoms (other than cutaneous manifestations) attributable to an autoimmune disease, including SLE, in the past 2 years?
☐ Yes ☐ No

b. Does the Veteran have arthritis attributable to an autoimmune disease, including SLE?
☐ Yes ☐ No
If yes, list affected joints and describe affect of autoimmune disease on each joint (brief summary):
_____
ALSO complete appropriate Questionnaire for each affected joint.

c. Does the Veteran have recurrent ulcers on oral mucous membranes attributable to an autoimmune disease, including SLE?
☐ Yes ☐ No
If yes, do the recurrent ulcers results in impairment of mastication, a speech impairment or other signs or symptoms?
☐ Yes ☐ No
If yes, describe: _____

d. Does the Veteran have any hematologic or lymphatic manifestations of an autoimmune disease, including SLE?
☐ Yes ☐ No
If yes, check all that apply:
☐ Generalized adenopathy
☐ Splenomegaly
☐ Anemia
☐ Leukopenia (usually lymphopenia, with < 1500 cells/µL)
☐ Thrombocytopenia (sometimes life-threatening autoimmune thrombocytopenia)
☐ Other, describe: _____

e. Does the Veteran have any pulmonary manifestations of an autoimmune disease, including SLE?
☐ Yes ☐ No
If yes, check all that apply (ALSO complete a Respiratory Questionnaire, including pulmonary function testing, if appropriate, on the Respiratory Questionnaire):
☐ Pulmonary emboli
☐ Pulmonary hypertension
☐ Shrinking lung syndrome
☐ Recurrent pleurisy, with or without pleural effusion
☐ Other, describe: _____

f. Does the Veteran have any cardiac manifestations of an autoimmune disease, including SLE?
☐ Yes ☐ No
If yes, check all that apply (ALSO complete a Heart Questionnaire):
- ☐ Pericardial effusion
- ☐ Myocarditis
- ☐ Coronary artery vasculitis
- ☐ Valvular involvement
- ☐ Libman-Sacks endocarditis
- ☐ Other, describe: _____

g. Does the Veteran have any neurologic manifestations of an autoimmune disease, including SLE?
☐ Yes ☐ No
If yes, describe (ALSO complete the appropriate neurologic Questionnaire): _____

h. Does the Veteran have any renal manifestations of an autoimmune disease, including SLE?
☐ Yes ☐ No
If yes, check all that apply (ALSO complete the appropriate Kidney and/or Hypertension Questionnaire):
- ☐ Glomerular nephritis
- ☐ Membranoproliferative glomerulonephritis.
- ☐ Proteinuria
- ☐ Hypertension
- ☐ Edema
- ☐ Other, describe: _____

i. Does the Veteran have any obstetric manifestations of an autoimmune disease, including SLE?
☐ Yes ☐ No
If yes, describe: _____

j. Does the Veteran have any gastrointestinal manifestations of an autoimmune disease, including SLE?
☐ Yes ☐ No
If yes, describe (ALSO complete the appropriate GI Questionnaire): _____

k. Does the Veteran have any vascular (arterial or venous) manifestations of an autoimmune disease, including SLE?
☐ Yes ☐ No
If yes, check all that apply (ALSO complete the Arteries & Veins Questionnaire):
- ☐ Recurrent arterial thrombosis
- ☐ Recurrent venous thrombosis
- ☐ Other, describe: _____

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

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

a. Have imaging studies been performed?
☐ Yes ☐ No
If yes, check all that apply:
- ☐ Chest x-ray Date: _____ Results: _____
- ☐ Magnetic resonance imaging (MRI) Date: _____ Results: _____
- ☐ Computed tomography (CT) Date: _____ Results: _____

☐ Other: _____ Date: _____ Results: _____

b. Has laboratory testing been performed?
☐ Yes ☐ No
If yes, check all that apply:

☐ Hemoglobin (gm/100ml) Date: _____ Results: _____
☐ Hematocrit Date: _____ Results: _____
☐ Red blood cell (RBC) count Date: _____ Results: _____
☐ White blood cell (WBC) count Date: _____ Results: _____
☐ White blood cell differential count Date: _____ Results: _____
☐ Platelet count: Date: _____ Results: _____
☐ Erythrocyte sedimentation rate (ESR) Date: _____ Results: _____
☐ C-reactive protein (CRP) Date: _____ Results: _____
☐ Antinuclear antibody (ANA) titer Date: _____ Results: _____
☐ Anti-Ro Antibody Date: _____ Results: _____
☐ Anti-Smith antibodies Date: _____ Results: _____
☐ Anti-double strand (ds) DNA Date: _____ Results: _____
☐ Antiphospolipid Date: _____ Results: _____
☐ Complement components (C3 and C4) Date: _____ Results: _____
☐ BUN Date: _____ Results: _____
☐ Creatinine Date: _____ Results: _____
☐ Estimated glomerular filtration rate (EGFR)
Date: _____ Results: _____
☐ Other, specify: _____ Date: _____ Results: _____

c. Has a urinalysis been performed?
☐ Yes ☐ No
Date of most recent urinalysis: _____
Results:
Microalbumin: ☐ Not elevated ☐ Elevated to: _____
Protein: ☐ None ☐ Trace ☐ 1+ ☐ 2+ ☐ 3+
Glucose: ☐ None ☐ Trace ☐ 1+ ☐ 2+ ☐ 3+
Hyaline casts: ☐ None ☐ 1-5 hyaline casts per LPF ☐ Other, describe: _____
Granular casts: ☐ None ☐ 1-5 granular casts per LPF ☐ Other, describe: _____
Blood: ☐ None ☐ Trace blood and no RBCs per HPF
☐ Trace blood and 1-5 RBCs per HPF ☐ 1+ blood and 1-5 RBCs per HPF
☐ 1+ blood and 5-10 RBCs per HPF ☐ 2+ blood and 10-20 RBCs per HPF
☐ Other, describe: _____

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

7. Functional impact
Does the Veteran's autoimmune disease impact his or her ability to work?
☐ Yes ☐ No
If yes, describe impact of the Veteran's autoimmune disease, providing one or more examples:
_____

8. Remarks, if any: _____

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

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

6.23. DBQ Thyroid and Parathyroid Conditions

Name of patient/Veteran: _____SSN: _____

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

1. Diagnosis

Does the Veteran have or has he/she ever had a thyroid or parathyroid condition?
☐ Yes ☐ No

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

- ☐ Hyperthyroidism ICD code: _____ Date of diagnosis: _____
- ☐ Toxic adenoma of thyroid ICD code: _____ Date of diagnosis: _____
- ☐ Non-toxic adenoma of thyroid (euthyroid) ICD code: _____ Date of diagnosis: _____
- ☐ Euthyroid multinodular goiter ICD code: _____ Date of diagnosis: _____
- ☐ Hypothyroidism ICD code: _____ Date of diagnosis: _____
- ☐ Hyperparathyroidism ICD code: _____ Date of diagnosis: _____
- ☐ Hypoparathyroidism ICD code: _____ Date of diagnosis: _____
- ☐ C-cell hyperplasia ICD code: _____ Date of diagnosis: _____
- ☐ Benign neoplasm of the thyroid ICD code: _____ Date of diagnosis: _____
- ☐ Malignant neoplasm of the thyroid ICD code: _____ Date of diagnosis: _____
- ☐ Benign neoplasm parathyroid ICD code: _____ Date of diagnosis: _____
- ☐ Malignant neoplasm parathyroid ICD code: _____ Date of diagnosis: _____
- ☐ Other, specify:

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

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

If there are additional diagnoses that pertain to thyroid and/or parathyroid conditions, list using above format: ____

2. Medical history

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

b. Is continuous medication required for control of a thyroid or parathyroid condition?
☐ Yes ☐ No
If yes, state the condition and list only those medications required for the Veteran's thyroid and/or parathyroid condition: _____

c. Has the Veteran had radioactive iodine treatment for a thyroid condition?
☐ Yes ☐ No
If yes, specify the condition and type of treatment: _____
Date of treatment: _____

d. Has the Veteran had surgery for a thyroid or parathyroid condition?
☐ Yes ☐ No
If yes, specify the condition and type of surgery: _____
Date of surgery: _____

e. Has the Veteran had any other type of treatment for a thyroid or parathyroid condition?
☐ Yes ☐ No
If yes, specify the condition and type of treatment: _____
Date of treatment: _____

f. Does the Veteran have any residual endocrine dysfunction following treatment for thyroid or parathyroid condition?
☐ Yes ☐ No
If yes, check all that apply:
☐ Hypothyroid endocrine dysfunction
☐ Hypoparathyroid endocrine dysfunction
☐ Other, describe: _____

3. Findings, signs and symptoms

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

☐ Yes ☐ No

If yes, check all that apply:
☐ Tachycardia (more than 100 beats per minute)
If checked, indicate frequency of tachycardia: ☐ Constant ☐ Intermittent
☐ Palpitations
☐ Atrial fibrillation or other arrhythmia attributable to a thyroid condition
If checked, indicate frequency: ☐ Constant ☐ Intermittent (paroxysmal)
If intermittent, indicate number of episodes in the past 12 months:
☐ 0 ☐ 1-3 ☐ More than 4
Indicate how these episodes were documented (check all that apply)
☐ EKG ☐ Holter ☐ Other, specify: _____
☐ Increased pulse pressure or blood pressure
☐ Tremor
☐ Emotional instability
☐ Fatigability
☐ Thyroid enlargement
☐ Eye involvement (exophthalmos)
If checked, an Eye DBQ must ALSO be completed.
☐ Muscular weakness
☐ Increase sweating
☐ Flushing
☐ Heat intolerance
☐ Frequent bowel movements
☐ Irregular or absent menstrual periods in women
☐ Weight loss attributable to a hyperthyroid condition
If checked, provide baseline weight: _____ and current weight: _____
(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

For all checked conditions or for any other conditions, describe: _____

b. Does the Veteran currently have any findings, signs or symptoms attributable to a hypothyroid condition?
☐ Yes ☐ No
If yes, check all that apply:
☐ Fatigability

☐ Constipation

☐ Mental sluggishness
☐ Mental disturbance (dementia, slowing of thought, depression)
☐ Muscular weakness
☐ Weight gain attributable to a hypothyroid condition
If checked, provide baseline weight: _____ and current weight: _____
(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)
☐ Sleepiness
☐ Cold intolerance
☐ Bradycardia (less than 60 beats per minute)
For all checked conditions or for any other conditions, describe: _____

c. Does the Veteran currently have any findings, signs or symptoms attributable to a hyperparathyroid condition?
☐ Yes ☐ No
If yes, check all that apply:
☐ Weakness

☐ Kidney stones
If checked, describe, providing dates and treatment: _____
☐ Generalized decalcification of bones
If checked, has the Veteran had a bone density test, such as a DEXA scan?
☐ Yes ☐ No
If yes, provide date of test: _____ Results: _____
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Anorexia
☐ Peptic ulcer
☐ Weight loss attributable to hyperparathyroid condition
If checked, provide baseline weight: _____ and current weight: _____
(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

For all checked conditions or for any other conditions, describe: _____

d. Does the Veteran currently have any findings, signs or symptoms attributable to hypoparathyroid condition?
☐ Yes ☐ No
If yes, check all that apply:
☐ Paresthesias (of arms, legs or circumoral area)
☐ Cataract
If checked, an Eye DBQ must also be completed.
☐ Evidence of increased intracranial pressure (such as papilledema)
☐ Marked neuromuscular excitability
☐ Convulsions
☐ Muscular spasms (tetany)
☐ Laryngeal stridor
☐ Other, describe: _____

e. Does the Veteran currently have symptoms due to pressure on adjacent organs such as the trachea, larynx, or esophagus attributable to a thyroid condition?
☐ Yes ☐ No
If yes, indicate which adjacent organs are affected:
☐ Larynx and/or trachea
If checked, report pulmonary function testing results in diagnostic testing section.
☐ Esophagus
If checked, indicate severity of pressure-related symptoms/swallowing difficulty (check all that apply):
☐ Mild ☐ Moderate ☐ Severe, permitting the passage of liquids only ☐ Causing marked impairment of health

4. Physical exam

a. Eyes: ☐ Normal, no exopthalmos
☐ Abnormal
If checked describe: _____
If abnormal, an Eye DBQ must also be completed.

b. Neck: ☐ Normal, no palpable thyroid enlargement or nodules
☐ Abnormal, diffusely enlarged thyroid gland
☐ Abnormal, enlarged thyroid nodule
If checked, describe location, size and consistency: _____
☐ Abnormal, with disfigurement of the head or neck due to enlargement of the thyroid gland
If checked, describe by following Section 6 below: _____
☐ Other, describe: _____

c. Pulse: ☐ Regular ☐ Irregular
Heart rate: _____

d. Blood pressure x3 _____

5. Reflex exam

Rate deep tendon reflexes (DTRs) according to the following scale:
0 Absent
1+ Hypoactive
2+ Normal
3+ Hyperactive without clonus
4+ Hyperactive with clonus

☐ All normal

Biceps:	Right:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	Left:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Triceps:	Right:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	Left:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Brachioradialis:	Right:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	Left:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Knee:	Right:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	Left:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Ankle:	Right:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
	Left:	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+

6. Scars or other disfigurement of the neck

Does the Veteran have any scars of the neck related to treatment for any thyroid or parathyroid condition?
☐ Yes ☐ No
If yes, complete the following:
a. Total number of unstable or painful scars: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more
b. Is any scar 13 cm in length or longer?
☐ Yes ☐ No
c. Is any scar 0.6 cm in width or wider?
☐ Yes ☐ No
d. Is any scar elevated or depressed?
☐ Yes ☐ No
e. Is any scar adherent to underlying tissue?
☐ Yes ☐ No

Does the Veteran have any areas of skin of the neck that are hypo- or hyperpigmented, that have abnormal texture, that have missing underlying soft tissue, or that are indurated and inflexible due to thyroid or parathyroid disease or their treatment?
☐ Yes ☐ No

a. If yes, provide approximate total area of skin with hypo- or hyperpigmented area(s): _____ cm2

b. If yes, provide approximate total area of skin with area(s) of abnormal texture: _____cm2

c. If yes, provide approximate total area of skin with area(s) of missing underlying soft tissue: _____ cm2

d. If yes, provide approximate total area of skin with area(s) that are indurated and inflexible: _____ cm2

7. Tumors and neoplasms

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

☐ Yes ☐ No

If yes, complete the following section:

a. Is the neoplasm:

☐ Benign ☐ Malignant

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

☐ Yes ☐ No; watchful waiting

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

☐ Treatment completed; currently in watchful waiting status

☐ Surgery

If checked, describe: _____

Date(s) of surgery: _____

☐ Radiation therapy

Date of most recent treatment: _____

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

☐ Antineoplastic chemotherapy

Date of most recent treatment: _____

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

☐ Other therapeutic procedure

If checked, describe procedure: _____

Date of most recent procedure: _____

☐ Other therapeutic treatment

If checked, describe treatment: _____

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

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

☐ Yes ☐ No

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

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

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

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

☐ Yes ☐ No

If yes, describe (brief summary): _____

9. Diagnostic testing

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

a. Have imaging studies been performed?
☐ Yes ☐ No
If yes, check all that apply:

☐ Magnetic resonance imaging (MRI)	Date: _____	Results: _____
☐ Computed tomography (CT)	Date: _____	Results: _____
☐ Thyroid scan	Date: _____	Results: _____
☐ Thyroid ultrasound	Date: _____	Results: _____
☐ Other: _____	Date: _____	Results: _____

b. Has laboratory testing been performed?
☐ Yes ☐ No
If yes, check all that apply and provide date of most recent test and results:

☐ TSH	Date: _____	Results: _____
☐ T4	Date: _____	Results: _____
☐ T3	Date: _____	Results: _____
☐ Thyroid antibodies	Date: _____	Results: _____
☐ Parathyroid hormone (PTH)	Date: _____	Results: _____
☐ Calcium	Date: _____	Results: _____
☐ Ionized calcium	Date: _____	Results: _____
☐ Other: _____	Date: _____	Results: _____

c. Have pulmonary function tests (PFTs) been performed?
NOTE: For VA purposes, PFTs should be performed if there is pressure on the larynx or trachea attributable to a thyroid condition.
☐ Yes ☐ No
If yes, provide most recent results, if available:
FEV-1: _____% predicted Date: _____
FEV-1/FVC: _____ Date: _____
FVC: _____% predicted Date: _____
Is flow-volume loop compatible with upper airway obstruction?
☐ Yes ☐ No

d. Has a biopsy been performed?
☐ Yes ☐ No Site of biopsy: _____ Date of test: _____ Results: _____

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

10. Functional impact
Does the Veteran's thyroid or parathyroid condition impact his or her ability to work?
☐ Yes ☐ No
If yes, describe impact of the Veteran's thyroid and/or parathyroid condition, providing one or more examples: ___

11. Remarks, if any: _____

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

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

6.24. DBQ Urinary Tract (including Bladder & Urethra) Conditions (excluding Male Reproductive Organs)

Name of patient/Veteran: _____ SSN: _____

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

1. Diagnosis:

Does the Veteran now have or has he/she ever been diagnosed with a condition of the bladder or urethra of the urinary tract?

☐ Yes ☐ No

If yes, provide only diagnoses that pertain to urinary tract conditions of the bladder or urethra.

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

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

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

If there are additional diagnoses that pertain to the bladder or urethra, list using above format: _____

2. Medical history

Describe the history (including onset and course) the Veteran's urinary tract condition (brief summary):

_____

3. Voiding dysfunction

Does the Veteran have a voiding dysfunction?

☐ Yes ☐ No

If yes, complete the following section:

a. Etiology of voiding dysfunction (i.e., relationship of voiding dysfunction to any condition in the Diagnosis section):

_____

b. Does the voiding dysfunction cause urine leakage?

☐ Yes ☐ No

Indicate severity (check one):

- ☐ Does not require the wearing of absorbent material
- ☐ Requires absorbent material which must be changed less than 2 times per day
- ☐ Requires absorbent material which must be changed 2 to 4 times per day
- ☐ Requires absorbent material which must be changed more than 4 times per day
- ☐ Other, describe: _____

c. Does the voiding dysfunction require the use of an appliance?

☐ Yes ☐ No

If yes, describe the appliance: _____

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

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

4. Urolithiasis
Does the Veteran have a history of urethral or bladder calculi (cysto- or urethrolithiasis)?
☐ Yes ☐ No
If yes, complete the following section:

a. Indicate location of calculi (check all that apply):
☐ Urethra ☐ Bladder

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

c. Does the Veteran have signs or symptoms due to cysto- or urethrolithiasis?
☐ Yes ☐ No
If yes, indicate type/severity (check all that apply):
- ☐ Bladder pain
- ☐ Dysuria

☐ Hematuria
☐ Voiding dysfunction
☐ Requirement for catheter drainage
☐ Sudden painful interruption of urinary stream

For all checked conditions or for any other conditions, describe: _____

5. Bladder or urethral infection

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

a. Provide etiology (i.e., relationship of recurrent symptomatic bladder or urethral infections to any condition in the Diagnosis section): _____

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

6. Other bladder/urethral conditions

Does the Veteran now have or has the Veteran had a bladder or urethral fistula, stricture, neurogenic bladder or bladder injury?
☐ Yes ☐ No
If yes, complete the following section:

a. Does the Veteran have any findings, signs or symptoms attributable to a bladder or urethral fistula?
☐ Yes ☐ No

If yes, check all that apply:
☐ Voiding dysfunction (urine leakage, obstructed voiding)
☐ Requirement for catheter drainage
☐ Infection (cystitis or urethritis)
☐ Impaired kidney function
If the Veteran has impaired kidney function, also complete Nephrology (Kidney Conditions) Questionnaire.
☐ Other, describe: _____

b. Has the Veteran had surgery for a bladder or urethral fistula?
☐ Yes ☐ No
If yes, indicate surgical treatment:
☐ None
☐ Resection or closure of fistula Date and facility of treatment: _____
☐ Urinary diversion Date and facility of treatment: _____

☐ Partial bladder resection Date and facility of treatment: _____
☐ Other, describe: _____ Date and facility of treatment: _____

c. Does the Veteran have a neurogenic bladder?
☐ Yes ☐ No
If yes, describe: _____

d. Has the Veteran had a bladder injury?
☐ Yes ☐ No
If yes, describe: _____

7. Tumors and neoplasms

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

a. Is the neoplasm:
☐ Benign ☐ Malignant

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

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

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

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

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

If yes, also complete a Scars Questionnaire.

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

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

Has the Veteran had diagnostic testing and if so, are there significant findings and/or results?
☐ Yes ☐ No
If yes, provide type of test or procedure, date and results (brief summary): _____

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

11. Remarks, if any: _____
Physician signature: _____ Date: _____
Physician printed name: _____
Medical license #: _____ Physician address: _____
Phone: _____ Fax: _____

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

7. Software and Documentation Retrieval

7.1 Software

The VistA software is being distributed as a PackMan patch message through the National Patch Module (NPM). The KIDS build for this patch is DVBA*2.7*175.

7.2 User Documentation

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

download.vista.med.va.gov

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

OI&T Field Office	FTP Address	Directory
Albany	ftp.fo-albany.med.va.gov	[anonymous.software]
Hines	ftp.fo-hines.med.va.gov	[anonymous.software]
Salt Lake City	ftp.fo-slc.med.va.gov	[anonymous.software]

File Name	Format	Description
DVBA_27_P175_RN.PDF	Binary	Release Notes
DVBA_27_P175_DBQ_MALEREPRODUCTIVE_WF.docx	Binary	Workflow Document

7.3 Related Documents

The VistA Documentation Library (VDL) web site will also contain the DVBA*2.7*175 Release Notes and Workflow Documents. This web site is usually updated within 1-3 days of the patch release date.

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

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