

Name of Claimant/Veteran:

Claimant/Veteran's Social Security Number:

Date of Examination:

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) **WILL NOT PAY OR REIMBURSE** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM.

Note - The Veteran 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. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the veteran's application. VA reserves the right to confirm the authenticity of ALL questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

 Veteran/Claimant

 Other: please describe

 Are you a VA Healthcare provider? Yes No

 Is the Veteran regularly seen as a patient in your clinic? Yes No

 Was the Veteran examined in person? Yes No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

 No records were reviewed

 Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

DOMINANT HAND

 Dominant hand: Right Left Ambidextrous

SECTION I - DIAGNOSIS

Note: These are condition(s) for which an evaluation has been requested on an exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. List the claimed condition(s) that pertain to this questionnaire:

Note: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in the remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date determined through record review or reported history.

 1B. Does the Veteran now have or has he or she ever had a vascular disease (arterial or venous)? Yes No

If yes, provide only diagnoses that pertain to vascular disease (arterial or venous):

<input type="checkbox"/> Varicose veins	ICD Code	Date of diagnosis
<input type="checkbox"/> Post-phlebitic syndrome (of any etiology)	ICD Code	Date of diagnosis
<input type="checkbox"/> Aneurysm, any large artery	ICD Code	Date of diagnosis
<input type="checkbox"/> Aortic aneurysm: ascending, thoracic or abdominal	ICD Code	Date of diagnosis
<input type="checkbox"/> Aneurysm of a small artery	ICD Code	Date of diagnosis
<input type="checkbox"/> Raynaud's disease (also known as primary Raynaud's)	ICD Code	Date of diagnosis
<input type="checkbox"/> Raynaud's syndrome (also known as secondary Raynaud's phenomenon or secondary Raynaud's)	ICD Code	Date of diagnosis

SECTION I - DIAGNOSIS (Continued)

1B. Continued

<input type="checkbox"/> Erythromelalgia	ICD Code	Date of diagnosis
<input type="checkbox"/> Angioneurotic edema	ICD Code	Date of diagnosis
<input type="checkbox"/> Thrombo-angiitis obliterans (Buerger's disease)	ICD Code	Date of diagnosis
<input type="checkbox"/> Arteriovenous (AV) fistula, traumatic	ICD Code	Date of diagnosis
<input type="checkbox"/> Soft tissue sarcoma of vascular origin	ICD Code	Date of diagnosis
<input type="checkbox"/> Peripheral arterial disease	ICD Code	Date of diagnosis
<input type="checkbox"/> Syphilitic aortic aneurysm	ICD Code	Date of diagnosis

1C. If there are additional diagnoses that pertain to vascular diseases, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history, including onset and course of the Veteran's vascular condition(s). Brief summary:

SECTION III - VARICOSE VEINS AND/OR POST- PHLEBITIC SYNDROME

3A. Does the Veteran have or has ever had varicose veins? Yes No
 If yes, indicate extremity: Upper Right Left Both Lower Right Left Both

3B. Does the Veteran have or has ever had post-phlebitic syndrome of any etiology? Yes No
 If yes, indicate extremity: Upper Right Left Both Lower Right Left Both

3C. Check all symptoms that apply and indicate extremity affected:

	Upper			Lower		
<input type="checkbox"/> Asymptomatic palpable varicose veins	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Asymptomatic visible varicose veins	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Aching in leg after prolonged standing	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Fatigue in leg after prolonged standing	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Aching in leg after prolonged walking	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Fatigue in leg after prolonged walking	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Symptoms relieved by elevation of extremity	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Symptoms relieved by compression hosiery	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Constant pain at rest	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both

3D. Check all findings and/or signs that apply and indicate extremity affected:

	Upper			Lower		
<input type="checkbox"/> Beginning stasis pigmentation	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Persistent stasis pigmentation	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Beginning eczema	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Persistent edema	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Intermittent edema of extremity	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Persistent edema that is incompletely relieved by elevation of extremity	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Massive board-like edema	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Intermittent ulceration	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Persistent ulceration	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Persistent subcutaneous induration	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both

SECTION IV - PERIPHERAL ARTERIAL DISEASE AND THROMBO-ANGIITIS OBLITERANS (BUERGER'S DISEASE)

4A. Has the Veteran ever been diagnosed with any of the following? Check all that apply: Yes No

- Peripheral arterial disease
- Thrombo-angiitis obliterans (Buerger's Disease)
- Other _____

If any of the above conditions are checked, answer questions 4B - 4D.

SECTION IV - PERIPHERAL ARTERIAL DISEASE AND THROMBO-ANGIITIS OBLITERANS (BUERGER'S DISEASE) (Continued)

4B. Has the Veteran undergone surgery for any of the listed conditions? Yes No

If yes list type of surgery: _____ Date of surgery: _____

4C. Has the Veteran undergone any procedure other than surgery for revascularization? Yes No

If yes list type of procedure: _____ Date of procedure: _____

4D. Indicate severity of current signs and symptoms and indicate side of upper extremity affected. Check all that apply:

Note: Trophic changes include, but are not limited to, skin changes (thinning, atrophy, fissuring, ulceration, scarring, absence of hair) as well as nail changes (clubbing, deformities).

- | | | | |
|--|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Diminished upper extremity pulses | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Trophic changes | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Numbness and paresthesia at the tips of the fingers | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Pains in the hand during physical activity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Deep ischemic ulcers | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Necrosis of the fingers | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Persistent coldness of the extremity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

SECTION V - ANEURYSM, ANY LARGE ARTERY

5A. Has the Veteran ever been diagnosed with an aneurysm of any large artery other than aorta? Yes No

If yes, is it symptomatic? Yes No

If a large aneurysm has been diagnosed, has the Veteran had a surgical procedure for the aneurysm? Yes No

If yes, indicate type of surgery: _____ Date of surgery: _____

If no surgery has been done, is an aneurysm present that does not meet the requirements for surgical correction? Yes No

SECTION VI - AORTIC ANEURYSM: ASCENDING, THORACIC, OR ABDOMINAL

6A. Has the Veteran ever been diagnosed with an aortic aneurysm: ascending, thoracic, or abdominal? Yes No

If yes, is it symptomatic? Yes No

Has the Veteran had a surgical procedure for an aortic aneurysm: ascending, thoracic, or abdominal? Yes No

If yes, indicate type of surgery: _____ Date of surgery: _____

If no, is an aneurysm present that does not meet the requirements for surgical correction? Yes No

6B. Does the Veteran currently have an aortic aneurysm, ascending, thoracic, or abdominal? Yes No

If yes, indicate severity:

Five centimeters or larger in diameter Yes No

Symptomatic (e.g., precludes exertion) Yes No

6C. Does the Veteran have any post-surgical residuals due to treatment for aortic aneurysm, ascending, thoracic, or abdominal? Yes No

If yes, describe: _____

If there are non-cardiac symptoms or post-surgical residuals, complete appropriate questionnaire for affected body system.

SECTION VII - ANEURYSM OF A SMALL ARTERY

7A. Has the Veteran been diagnosed with an aneurysm of a small artery? Yes No

Is it symptomatic? Yes No

If yes, describe symptoms: _____

If yes, has the Veteran had a surgical procedure for an aneurysm of a small artery? Yes No

If yes, indicate type of surgery: _____ Date of surgery: _____

Does the Veteran currently have an aneurysm of a small artery? Yes No

Also complete appropriate questionnaire according to body system affected.

7B. Does the Veteran have any post-surgical residuals due to treatment for an aneurysm of a small artery? Yes No

If yes, describe: _____

If there are non-cardiac symptoms or post-surgical residuals, complete appropriate questionnaire according to body system affected.

SECTION VIII - RAYNAUD'S DISEASE OR SYNDROME

Note: Trophic changes include, but are not limited to, skin changes (thinning, atrophy, fissuring, ulceration, scarring, absence of hair) as well as nail changes (clubbing, deformities).

For Raynaud's disease, characteristic attacks consist of intermittent and episodic color changes of the digits of one or more extremities, lasting minutes or longer, with occasional pain and paresthesias, and precipitated by exposure to cold or by emotional upsets.

For Raynaud's syndrome, characteristic attacks consist of sequential color changes of the digits of one or more extremities, lasting minutes to hours, sometimes with pain and paresthesias, and precipitated by exposure to cold or by emotional upsets.

8A. Does the Veteran have Raynaud's disease (also known as primary Raynaud's)? Yes No

8B. Does the Veteran have Raynaud's syndrome (also known as secondary Raynaud's phenomenon or secondary Raynaud's)? Yes No

8C. Is there a history of characteristic attacks? Yes No If yes, indicate frequency of characteristic attacks:
 Less than once a week 1 to 3 times a week 4 to 6 times a week At least daily
 With trophic changes Without trophic changes

8D. Does the Veteran have two or more digital ulcers? Yes No
 With trophic changes Without trophic changes

8E. Does the Veteran have auto-amputation of one or more digits? Yes No

SECTION IX - ARTERIOVENOUS (AV) FISTULA, ANGIONEUROTIC EDEMA OR ERYTHROMELALGIA

9A. Does the Veteran have or has ever had a traumatic AV fistula? Yes No

If yes, indicate site of traumatic AV fistula:

Right upper extremity Left upper extremity Other location, specify: _____
 Right lower extremity Left lower extremity

9B. Indicate findings:

Chronic edema
 Right upper extremity Left upper extremity
 Right lower extremity Left lower extremity
 Stasis dermatitis
 Right upper extremity Left upper extremity
 Right lower extremity Left lower extremity
 Ulceration
 Right upper extremity Left upper extremity
 Right lower extremity Left lower extremity
 Cellulitis
 Right upper extremity Left upper extremity
 Right lower extremity Left lower extremity

9C. Cardiovascular symptoms:

No cardiac involvement
 Enlarged heart
 Wide pulse pressure
 Tachycardia
 High-output heart failure

If related to traumatic AV fistula, complete Heart Conditions questionnaire.

9D. Is there more than one traumatic AV fistula? Yes No

If yes, provide location and findings for each traumatic AV fistula using the above format:

SECTION IX - ARTERIOVENOUS (AV) FISTULA, ANGIONEUROTIC EDEMA OR ERYTHROMELALGIA (Continued)

9E. Does the Veteran have chronic angioneurotic edema? Yes No

If yes, indicate severity, duration, and frequency of attacks. Check all that apply:

- With laryngeal involvement (of any duration)
- Without laryngeal involvement
- Duration:
 - Occurs 1 or 2 times a year
 - Occurs more than 2 times a year
 - Lasts 1 to 7 days
 - Lasts longer than 7 days
- Frequency:
 - Occurs less than 2 times a year
 - Occurs 2 to 4 times a year
 - Occurs 5 to 8 times a year
 - Occurs more than 8 times a year

Note: For purposes of this section, a characteristic attack of erythromelalgia consists of burning pain in the hands, feet, or both, usually bilateral and symmetrical, with increased skin temperature and redness, occurring at warm ambient temperatures.

9F. Does the Veteran have or has ever had an erythromelalgia? Yes No

If yes, indicate severity, duration and frequency of characteristic attacks. Check all that apply:

- Does not restrict most routine daily activities
- Restricts most routine daily activities
- Occurs less than 3 times a week
- Occurs at least 3 times a week
- Occurs daily
- Occurs more than once a day
- Lasts an average of more than 2 hours each
- Responds to treatment
- Responds poorly to treatment

SECTION X - TUMORS AND NEOPLASMS

10A. Does the Veteran currently have, or has had, a benign or malignant neoplasm or metastases related to any condition in the diagnosis section?

Yes No If yes, complete this section:

10B. The neoplasm is:

- Benign
- Malignant - if malignant, select all that apply:
 - Active In remission
 - Primary Secondary (metastatic) If secondary, indicate the primary site, if known: _____

10C. 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
 - Surgery, if checked, describe: _____ Date 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 selected, specify type of procedure: _____
 - Date of most recent procedure: _____ Date of completion of procedure or anticipated date of completion: _____
 - Other therapeutic treatment - If selected, specify type of treatment: _____
 - Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

SECTION X - TUMORS AND NEOPLASMS (continued)

10D. Does the Veteran currently have any residuals 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 residuals or complications (brief summary), and also complete the appropriate questionnaire:

10E. 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:

SECTION XI - AMPUTATION AND ASSISTIVE DEVICES

11A. Has the Veteran had an amputation of an extremity due to a vascular condition? Yes No

If yes, complete the Amputations Questionnaire.

11B. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible?

Yes No

If yes, identify assistive devices used. Check all that apply and indicate frequency:

- | | | | | |
|---------------------------------------|-------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Wheelchair | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Brace(s) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Crutch(es) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Cane(s) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Walker | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Other: _____ | | | | |

Frequency of use: Occasional Regular Constant

11C. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the device used for each condition:

11D. Due to a vascular condition, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance, propulsion, etc.

Yes, functioning is so diminished that amputation with prosthesis would equally well serve the Veteran
 No

If yes, indicate extremity(ies). Check all extremities for which this applies:

- Right upper
 Right lower
 Left upper
 Left lower

11E. For each checked extremity, describe loss of affected function, identify the condition causing loss of function and provide specific examples.
Brief summary:

SECTION XII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

12A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to the conditions listed in the diagnosis section above?

Yes No

If yes, describe:

12B. Does the Veteran have any scars or other disfigurement of the skin related to any conditions or to the treatment of any conditions listed in the diagnosis section?

Yes No

If yes, complete appropriate dermatological questionnaire.

12C. Comments, if any:

SECTION XIII - DIAGNOSTIC TESTING

Note: In cases where ABI testing does not clinically reflect the severity of the Veteran's peripheral arterial disease, and the examiner states that AP, TP, and/or TcPO2 testing is needed and not of record, the clinically appropriate testing (AP, TP, and/or TcPO2) is required.

13A. Has ankle/brachial index (ABI) testing been performed? Yes No

If unable to perform provide reason: _____

If yes, provide most recent results: _____

Right ankle/brachial index: _____ Date: _____

Left ankle/brachial index: _____ Date: _____

13B. If only ABI testing is available, does ABI sufficiently reflect the severity of the Veteran's peripheral arterial disease? Yes No N/A

13C. Provide the results and dates of testing for the following, if available:

Right ankle pressure (AP): _____ Date: _____

Left ankle pressure (AP): _____ Date: _____

Right toe pressure (TP): _____ Date: _____

Left toe pressure (TP): _____ Date: _____

Right foot transcutaneous oxygen tension (TcPO2): _____ Date: _____

Left foot transcutaneous oxygen tension (TcPO2): _____ Date: _____

13D. Are there any other significant diagnostic test findings that were reviewed in conjunction with this examination that are related to the claimed condition(s) and/or diagnosis(es)? Yes No

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

SECTION XIV - FUNCTIONAL IMPACT

Note: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

14A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?

Yes No

If yes, describe the functional impact of each condition, providing one or more examples:

SECTION XV - REMARKS

15A. Remarks (if any, please identify the section to which the remark pertains when appropriate).

SECTION XVI - EXAMINER'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

16A. Examiner's signature:

16B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

16C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

16D. Date Signed:

16E. Examiner's phone/fax numbers:

16F. National Provider Identifier (NPI) number:

16G. Medical license number and state:

16H. Examiner's address:
