



NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

**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.

**SECTION I - DIAGNOSIS**

**NOTE:** The diagnosis of gastroesophageal reflux disease (GERD) can be made clinically by evidence of relief of typical symptoms of reflux, epigastric discomfort and/or burning, by treatment with proton pump inhibitors, histamine 2 receptor antagonists and/or antacids. If upper endoscopy was indicated or performed, the findings of erythema, ulcers and/or strictures are consistent with the diagnosis of GERD.

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN ESOPHAGEAL CONDITION?

YES  NO (If "Yes," complete Item 1B)

1B. DIAGNOSIS (Check all that apply)

- GASTROESOPHAGEAL REFLUX DISEASE (GERD) ICD CODE: \_\_\_\_\_ DATE OF DIAGNOSIS: \_\_\_\_\_
- HERNIA HIATAL ICD CODE: \_\_\_\_\_ DATE OF DIAGNOSIS: \_\_\_\_\_
- ESOPHAGUS, STRICTURE OF ICD CODE: \_\_\_\_\_ DATE OF DIAGNOSIS: \_\_\_\_\_
- ESOPHAGUS, SPASM OF (*cardiospasm*) ICD CODE: \_\_\_\_\_ DATE OF DIAGNOSIS: \_\_\_\_\_
- ESOPHAGUS, DIVERTICULUM OF, ACQUIRED ICD CODE: \_\_\_\_\_ DATE OF DIAGNOSIS: \_\_\_\_\_
- OTHER ESOPHAGEAL CONDITION(S), specify: (*such as eosinophilic esophagitis, Barrett's esophagitis, etc.*)
- OTHER DIAGNOSIS #1: \_\_\_\_\_ ICD CODE: \_\_\_\_\_ DATE OF DIAGNOSIS: \_\_\_\_\_
- OTHER DIAGNOSIS #2: \_\_\_\_\_ ICD CODE: \_\_\_\_\_ DATE OF DIAGNOSIS: \_\_\_\_\_

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO ESOPHAGEAL DISORDERS, LIST USING ABOVE FORMAT:

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (*including onset and course*) OF THE VETERAN'S ESOPHAGEAL CONDITIONS (*brief summary*):

2B. 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 - SIGNS AND SYMPTOMS**

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR SYMPTOMS DUE TO ANY ESOPHAGEAL CONDITIONS (*including GERD*)?

YES  NO

(If "Yes," check all that apply)

- SYMPTOMS PRODUCTIVE OF CONSIDERABLE IMPAIRMENT OF HEALTH
- SYMPTOMS COMBINATION PRODUCTIVE OF SEVERE IMPAIRMENT OF HEALTH
- PERSISTENTLY RECURRENT EPIGASTRIC DISTRESS
- INFREQUENT EPISODES OF EPIGASTRIC DISTRESS
- DYSPHAGIA
- PYROSIS
- REFLUX
- REGURGITATION
- PAIN

- Substernal
- Arm
- Shoulder

SLEEP DISTURBANCE CAUSE BY ESOPHAGEAL REFLUX

If checked, indicate frequency of symptom recurrence per year:

- 1  2  3  4 or more

If checked, indicate average duration of episodes of symptoms:

- Less than 1 day  1-9 days  10 days or more

MATERIAL 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)

**SECTION III - SIGNS AND SYMPTOMS (Continued)**

NAUSEA

If checked, indicate frequency of episodes of nausea per year:

1  2  3  4 or more

If checked, indicate average duration of episodes of nausea:

Less than 1 day  1-9 days  10 days or more

VOMITING

If checked, indicate frequency of episodes of vomiting per year:

1  2  3  4 or more

If checked, indicate average duration of episodes of vomiting:

Less than 1 day  1-9 days  10 days or more

HEMATEMESIS

If checked, indicate frequency of episodes of hematemesis per year:

1  2  3  4 or more

If checked, indicate average duration of episodes of hematemesis:

Less than 1 day  1-9 days  10 days or more

MELENA WITH MODERATE ANEMIA

If checked, provide hemoglobin/hematocrit in diagnostic testing section

If checked, indicate frequency of episodes of melena per year:

1  2  3  4 or more

If checked, indicate average duration of episodes of melena:

Less than 1 day  1-9 days  10 days or more

**SECTION IV - ESOPHAGEAL STRICTURE, SPASM AND DIVERTICULA**

4. DOES THE VETERAN HAVE AN ESOPHAGEAL STRICTURE, SPASM OF ESOPHAGUS (CARDIOSPASM OR ACHALASIA), OR AN ACQUIRED DIVERTICULUM OF THE ESOPHAGUS?

YES  NO

If Yes, indicate severity of condition:

ASYMPTOMATIC

NOT AMENABLE TO DILATION

AMENABLE TO DILATION

MILD If checked, describe: \_\_\_\_\_

MODERATE If checked, describe: \_\_\_\_\_

SEVERE If checked, describe: \_\_\_\_\_

PERMITTING LIQUIDS ONLY

PERMITTING PASSAGE OF LIQUIDS ONLY, WITH MARKED IMPAIRMENT OF GENERAL HEALTH

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

5A. 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 (*brief summary*):

**SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS (Continued)**

5B. 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 THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM (*6 square inches*); OR ARE LOCATED ON THE HEAD, FACE OR NECK? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

YES  NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION: \_\_\_\_\_ MEASUREMENTS: length \_\_\_\_\_ cm X width \_\_\_\_\_ cm.

**NOTE:** If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

5C. COMMENTS, IF ANY:

**SECTION VI - DIAGNOSTIC TESTING**

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

6A. HAVE DIAGNOSTIC IMAGING STUDIES OR OTHER DIAGNOSTIC PROCEDURES BEEN PERFORMED?

YES  NO

If Yes, check all that apply:

UPPER ENDOSCOPY

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

UPPER GI RADIOGRAPHIC STUDIES

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

ESOPHAGRAM (*barium swallow*)

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

MRI

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

CT

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

BIOPSY, SPECIFY SITE:

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

OTHER, SPECIFY:

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

6B. HAS LABORATORY TESTING BEEN PERFORMED?

YES  NO

If Yes, check all that apply:

CBC Date of testing: \_\_\_\_\_

Hemoglobin: \_\_\_\_\_ Hematocrit: \_\_\_\_\_ White blood cell count: \_\_\_\_\_ Platelets: \_\_\_\_\_

HELICOBACTER PYLORI Date of test: \_\_\_\_\_ Results: \_\_\_\_\_

OTHER, SPECIFY: \_\_\_\_\_ Date of test: \_\_\_\_\_ Results: \_\_\_\_\_

6C. 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 VII - FUNCTIONAL IMPACT**

7. DO ANY OF THE VETERAN'S ESOPHAGEAL CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

YES  NO

If Yes, describe impact of each of the veteran's esophageal conditions, providing one ore more examples:

**SECTION VIII - REMARKS**

8. REMARKS *(If any)*

**SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE**

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

9A. Examiner's signature:

9B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

9C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

9D. Date Signed:

9E. Examiner's phone/fax numbers:

9F. National Provider Identifier (NPI) number:

9G. Medical license number and state:

9H. Examiner's address: