



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.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN CURRENTLY HAVE A DIAGNOSIS OF HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION BASED ON THE FOLLOWING CRITERIA?

NOTE 1: For VA disability rating purposes, the term hypertension means that the diastolic blood pressure is predominantly 90mm or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm or greater with a diastolic blood pressure of less than 90mm.

NOTE 2: For VA purposes, the INITIAL diagnosis of hypertension or isolated systolic hypertension must be confirmed by readings taken 2 or more times on at least 3 different days. Blood pressure results may be obtained from existing medical records or through scheduled visits for blood pressure measurements.

Yes No (If yes, provide only diagnoses that pertain to hypertension):

<input type="checkbox"/> Hypertension	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Isolated systolic hypertension	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Other, specify:		
Other diagnosis #1: _____	ICD code: _____	Date of diagnosis: _____
Other diagnosis #2: _____	ICD code: _____	Date of diagnosis: _____

1B. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION, LIST USING ABOVE FORMAT:

NOTE 3: ALSO complete appropriate questionnaires for hypertension-related complications, if any (such as Kidney, if renal insufficiency is attributable to hypertension).

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (INCLUDING ONSET AND COURSE) OF THE VETERAN'S HYPERTENSION CONDITION (Brief summary):

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION?

Yes No (If yes, list only those medications used for the diagnosed conditions):

2C. WAS THE VETERAN'S INITIAL DIAGNOSIS OF HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION CONFIRMED BY BLOOD PRESSURE READINGS TAKEN 2 OR MORE TIMES ON AT LEAST 3 DIFFERENT DAYS?

Yes No Unknown (If checked, proceed to questions 2D and 2E)

(If yes, provide BP readings used to establish initial diagnosis, if known)

Reading # 1: /	Reading # 2: /	Date of Reading:
Reading # 1: /	Reading # 2: /	Date of Reading:
Reading # 1: /	Reading # 2: /	Date of Reading:

(If no, report BP readings taken 2 or more times on at least 3 different days in order to confirm diagnosis (unless Veteran is on treatment for hypertension.))

Reading # 1: /	Reading # 2: /	Date of Reading:
Reading # 1: /	Reading # 2: /	Date of Reading:
Reading # 1: /	Reading # 2: /	Date of Reading:

2D. DOES THE VETERAN HAVE A HISTORY OF A DIASTOLIC BP ELEVATION TO PREDOMINANTLY 100 OR MORE?

Yes No (If yes, describe frequency and severity of diastolic BP elevation):

2E. CURRENT (DATE OF EVALUATION/S) BLOOD PRESSURE READINGS** (SUFFICIENT IF VETERAN HAS A PREVIOUSLY ESTABLISHED DIAGNOSIS OF HYPERTENSION):

Reading # 1: /	Date of Reading: _____	**The Veteran should be seated comfortably with back and feet supported. There is no need to take lying or standing blood pressures. There is no specified time interval between readings and they may be completed sequentially.
Reading # 2: /	Date of Reading: _____	
Reading # 3: /	Date of Reading: _____	

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

3A. 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):

3B. 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, also complete appropriate dermatological DBQ)

3C. COMMENTS, IF ANY:

SECTION IV - FUNCTIONAL IMPACT

4A. DOES THE VETERAN'S HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION IMPACT HIS OR HER ABILITY TO WORK?

Yes No (If yes, describe the impact of the veteran's hypertension or isolated systolic hypertension, providing one or more examples):

SECTION V - REMARKS

5A. REMARKS (IF ANY):

SECTION VI - EXAMINER'S CERTIFICATION AND SIGNATURE

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

6A. Examiner's signature:

6B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

6C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

6D. Date Signed:

6E. Examiner's phone/fax numbers:

6F. National Provider Identifier (NPI) number:

6G. Medical license number and state:

6H. Examiner's address: