

## LOSS OF SENSE OF SMELL AND/OR TASTE DISABILITY BENEFITS QUESTIONNAIRE

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**

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH LOSS OF SENSE OF SMELL OR TASTE? *(This is the condition the Veteran is claiming or for which an exam has been requested.)*

YES  NO

1B. IF YES, SELECT THE VETERAN'S CONDITION *(check all that apply)*

<input type="checkbox"/> ANOSMIA <i>(inability to detect any odor)</i>	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> HYPOSMIA <i>(reduced ability to detect any odors)</i>	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> AGEUSIA <i>(complete lack of taste)</i>	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> HYPOGEUSIA <i>(decrease in sense of taste)</i>	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> OTHER <i>(specify)</i>		
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 COMPLETE LOSS OF SENSE OF SMELL OR TASTE, LIST USING ABOVE FORMAT:

**SECTION II - MEDICAL HISTORY**

2. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S LOSS OF SENSE OF SMELL OR TASTE *(brief summary)*:

**SECTION III - SYMPTOMS**

3A. 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)*

3B. 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)*

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

4A. 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 IV - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS (Continued)**

4B. 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.

4C. COMMENTS, IF ANY:

**SECTION V - DIAGNOSTIC TESTING**

**NOTE:** If testing has been performed and reflects the Veteran's current condition, repeat testing is not required. Specific diagnostic testing is not required for a loss of smell and taste examination.

5A. 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: \_\_\_\_\_

5B. HAS QUALITATIVE SMELL TESTING BEEN PERFORMED?

YES  NO (*If "Yes," complete the following*):

Type of test: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

5C. 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 VI - FUNCTIONAL IMPACT**

6. 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*):

**SECTION VII - REMARKS**

7. REMARKS (*If any*):

**SECTION VIII - EXAMINER'S CERTIFICATION AND SIGNATURE**

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

8A. Examiner's signature:

8B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):



8C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

8D. Date Signed:



8E. Examiner's phone/fax numbers:

8F. National Provider Identifier (NPI) number:

8G. Medical license number and state:




8H. Examiner's address: