Department of Veterans Affairs

ENDOCRINE DISEASES (Other than Thyroid, Parathyroid or Diabetes Mellitus)
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 HAVE OR HAS HE OR SHE EVER HAD AN ENDOCRINE CONDITION? *(This is the condition the veteran is claiming or for which an exam has been requested)*

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

1B. 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 *(adrenocortical insufficiency)* ICD code - _____ Date of diagnosis - _____

☐ POLYGLANDULAR SYNDROME *(multiple endocrine neoplasia, auto-immune polyglandular syndrome)* ICD code - _____ Date of diagnosis - _____

☐ HYPOPITUITARISM ICD code - _____ Date of diagnosis - _____

☐ HYPERPITUITARISM *(prolactin secreting pituitary dysfunction)* ICD code - _____ Date of diagnosis - _____

☐ BENIGN ☐ MALIGNANT

☐ ACTIVE ☐ IN REMISSION

☐ HYPERALDOSTERONISM ICD code - _____ Date of diagnosis - _____

☐ BENIGN ☐ MALIGNANT

☐ ACTIVE ☐ IN REMISSION

☐ PHEOCHROMOCYTOMA ICD code - _____ Date of diagnosis - _____

☐ BENIGN ☐ MALIGNANT

☐ ACTIVE ☐ IN REMISSION

☐ HYPOGONADISM ICD code - _____ Date of diagnosis - _____

☐ NEOPLASM, BENIGN, ANY SPECIFIED PART OF THE ENDOCRINE SYSTEM ICD code - _____ Date of diagnosis - _____

☐ NEOPLASM, MALIGNANT, ANY SPECIFIED PART OF THE ENDOCRINE SYSTEM ICD code - _____ Date of diagnosis - _____

☐ ACTIVE MALIGNANCY

☐ UNDERGOING SURGICAL, X-RAY, ANTINEOPLASTIC CHEMOTHERAPY OR OTHER THERAPEUTIC PROCEDURE

☐ IN REMISSION

☐ OTHER *(Specify)*:

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 ENDOCRINE CONDITION(S), LIST USING ABOVE FORMAT:

1D. PLEASE SELECT THE BODY SYSTEMS AFFECTED BY THE DIAGNOSES LISTED IN SECTION 1B.

☐ MUSCULOSKELETAL SYMPTOMS, (complete appropriate musculoskeletal DBQ)

☐ RESPIRATORY SYMPTOMS, (complete appropriate respiratory DBQ)

☐ CARDIOVASCULAR SYMPTOMS, (complete appropriate cardiovascular DBQ)

☐ GASTROINTESTINAL SYMPTOMS, (complete appropriate gastrointestinal DBQ)

☐ GENITOURINARY SYMPTOMS, (complete appropriate genitourinary DBQ)

☐ REPRODUCTIVE SYMPTOMS, (complete appropriate gynecological or male reproductive organ DBQ)

☐ SKIN SYMPTOMS, (complete appropriate dermatological DBQ)

☐ EYE INVOLVEMENT, (complete appropriate ophthalmological DBQ)

☐ NEUROLOGICAL SYMPTOMS, (complete appropriate neurological DBQ)

☐ MENTAL AND PSYCHOLOGICAL SYMPTOMS, (complete appropriate psychological DBQ)

☐ DENTAL AND ORAL CONDITIONS, (complete appropriate dental and oral DBQ)

SECTION II - MEDICAL HISTORY

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

2B. 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):

2C. HAS THE VETERAN HAD SURGERY FOR AN ENDOCRINE CONDITION?

☐ YES ☐ NO

(If "Yes," specify the condition and type of surgery): _____ *(Date of surgery):* _____

2D. 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):* _____

SECTION III - CUSHING'S SYNDROME

3A. CUSHING'S SYNDROME

(Date of initial diagnosis:) _____

Has it been more than 6 months since the initial diagnosis?

☐ YES ☐ NO

If yes, evaluate residuals with the appropriate DBQ (refer to and select appropriate checkbox from section 1D).

If no, please select the symptoms below:

☐ As active, progressive disease

☐ Areas of osteoporosis

☐ Hypertension

☐ Proximal upper extremity muscle wasting that results in inability to climb stairs

☐ Proximal upper extremity muscle wasting that results in inability to rise from a deep chair without assistance

☐ Proximal upper extremity muscle wasting that results in inability to rise from squatting position

☐ Proximal upper extremity muscle wasting that results in inability to raise arms

☐ Proximal lower extremity muscle wasting that results in inability to climb stairs

☐ Proximal lower extremity muscle wasting that results in inability to rise from a deep chair without assistance

☐ Proximal lower extremity muscle wasting that results in inability to rise from squatting position

☐ Proximal lower extremity muscle wasting that results in inability to raise arms

☐ Striae

☐ Obesity

☐ Moon face

☐ Glucose intolerance

☐ Vascular fragility

☐ Other, please specify: _____

SECTION IV - ACROMEGALY

4A. 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

☐ GLUCOSE INTOLERANCE

☐ ARTHROPATHY

☐ HYPERTENSION *(If checked, provide BPx3)*: _____

☐ EVIDENCE OF INCREASED INTRACRANIAL PRESSURE *(such as visual field defect)*

☐ CARDIOMEGALY

☐ OTHER *(Specify)*: _____

4B. DOES THE VETERAN CURRENTLY HAVE ANY ADDITIONAL FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO ACROMEGALY?

☐ YES ☐ NO

If yes, evaluate residuals with the appropriate DBQ pertaining to the affected body system.

SECTION V - DIABETES INSIPIDUS

5A. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO DIABETES INSIPIDUS?

☐ YES ☐ NO

(If "Yes," check all that apply)

☐ PERSISTENT POLYURIA

☐ REQUIRES CONTINUOUS HORMONAL THERAPY

5B. DOES THE VETERAN CURRENTLY HAVE ANY ADDITIONAL FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO DIABETES INSIPIDUS?

☐ YES ☐ NO

If yes, evaluate residuals with the appropriate DBQ pertaining to the affected body system.

5C. OTHER, DESCRIBE:

SECTION VI - ADDISON'S DISEASE (ADRENOCORTICAL INSUFFICIENCY)

6A. 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 AND 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

☐ OTHER *(Specify)*: _____

6B. FOR ALL CHECKED 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 not peripheral vascular collapse.

SECTION VII - OTHER ENDOCRINE CONDITIONS

7A. DOES THE VETERAN HAVE ANY OTHER ENDOCRINE CONDITIONS?

☐ YES ☐ NO

7B. IF YES, SPECIFY CONDITION AND DESCRIBE ANY CURRENT FINDINGS, SIGNS AND SYMPTOMS:

SECTION VIII - TUMORS AND NEOPLASMS

8A. 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)*

8B. IS THE NEOPLASM:

☐ BENIGN ☐ MALIGNANT

(If malignant, indicate status of disease)

☐ ACTIVE

- ☐ SURGERY *(If checked, describe)*: _____
- ☐ ANTINEOPLASTIC CHEMOTHERAPY
- ☐ RADIATION
- ☐ X-RAY TREATMENT
- ☐ WATCHFUL WAITING
- ☐ OTHER *(If checked, describe)*: _____

Anticipated date of final treatment (surgical, antineoplastic chemotherapy, radiation, X-ray treatment, or other): _____

☐ REMISSION

- ☐ SURGERY *(If checked, describe)*: _____
- ☐ ANTINEOPLASTIC CHEMOTHERAPY
- ☐ RADIATION
- ☐ X-RAY TREATMENT
- ☐ WATCHFUL WAITING
- ☐ OTHER *(If checked, describe)*: _____

Date treatment was completed or date of anticipated final treatment (surgical, antineoplastic chemotherapy, radiation, X-ray treatment, or other): _____

8C. 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)):

8D. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DESCRIBE USING THE ABOVE FORMAT:

SECTION IX - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

9A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO

(If "Yes," describe - brief summary)

SECTION IX - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS (Continued)

9B. 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 ABOVE?

☐ YES ☐ NO

(If "Yes," also complete appropriate dermatological DBQ)

9C. COMMENTS, IF ANY:

SECTION X - 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.

10A. 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: _____

10B. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO *(If "Yes," indicate type of test, date and results)*

Type of test: _____ Date: _____ Results: _____

Type of test: _____ Date: _____ Results: _____

Type of test: _____ Date: _____ Results: _____

10C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO

If "Yes," indicate type of test or procedure, date and results (brief summary):

SECTION XI - FUNCTIONAL IMPACT

11. 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)

SECTION XII - REMARKS

12. REMARKS *(If any)*

SECTION XIII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

13A. Examiner's signature:

13B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

13C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

13D. Date Signed:

13E. Examiner's phone/fax numbers:

13F. National Provider Identifier (NPI) number:

13G. Medical license number and state:

13H. Examiner's address: