

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 CURRENTLY HAVE A DIAGNOSED NUTRITIONAL DEFICIENCY?

YES NO

SECTION I - DIAGNOSIS (continued)

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

<input type="checkbox"/> AVITAMINOSIS	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> BERIBERI (Vitamin B1 or thiamine deficiency)	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> PELLAGRA (Vitamin B3 or niacin deficiency)	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> OTHER NUTRITIONAL DEFICIENCY CONDITION (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 NUTRITIONAL DEFICIENCIES, LIST USING ABOVE FORMAT:

NOTE - For all identified complications or residual conditions, ALSO complete additional questionnaires as appropriate (such as skin, heart, peripheral nerves, etc.)

SECTION II - MEDICAL HISTORY

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

2B. DOES THE VETERAN'S NUTRITIONAL DEFICIENCY CONDITION REQUIRE CONTINUOUS MEDICATIONS FOR CONTROL?

YES NO If "Yes," list medications used for nutritional deficiency conditions:

SECTION III - FINDINGS, SIGNS AND SYMPTOMS

3A. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO PELLAGRA OR AVITAMINOSIS?

YES NO If "Yes," check all that apply:

- Confirmed diagnosis
- Nonspecific symptoms such as decreased appetite, weight loss, abdominal discomfort, weakness, inability to concentrate and irritability
- Stomatitis
- Achlorhydria
- Diarrhea
- Symmetrical dermatitis
- Mental symptoms
- Impaired bodily vigor
- Marked mental changes, moist dermatitis, inability to retain nourishment, exhaustion and cachexia
- Other

FOR ALL CHECKED CONDITIONS, DESCRIBE:

SECTION III - FINDINGS, SIGNS AND SYMPTOMS (continued)

3B. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO ACTIVE BERIBERI?

YES NO If "Yes," check all that apply:

- Peripheral neuropathy with absent knee or ankle jerks and loss of sensation
- Symptoms such as weakness, fatigue, anorexia, dizziness, heaviness and stiffness of legs, headache, or sleep disturbance
- Cardiomegaly
- Peripheral neuropathy with foot drop or atrophy of thigh or calf muscles
- Congestive heart failure, anasarca, or Wernicke-Korsakoff syndrome
- Other

FOR ALL CHECKED CONDITIONS, DESCRIBE:

3C. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO RESIDUALS OF BERIBERI?

YES NO If "Yes," describe residual findings, signs and symptoms:

3D. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO CONDITIONS OR RESIDUALS CAUSED BY ANY OTHER VITAMIN DEFICIENCY?

YES NO If "Yes," describe:

NOTE: ALSO complete additional Questionnaires as appropriate (such as Mental Health, Skin, Peripheral Nerves, etc.) for all findings, signs, and symptoms identified above.

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

4A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

YES NO If "Yes," describe (brief summary):

4B. 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," also complete appropriate dermatological DBQ

4C. COMMENTS, IF ANY:

SECTION V - DIAGNOSTIC TESTING

NOTE: If testing has been completed and reflects Veteran's current condition, further testing is not required.

5A. ARE THERE ANY SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

YES NO If "Yes," describe:

SECTION VI - FUNCTIONAL IMPACT

6A. DOES THE VETERAN'S NUTRITIONAL DEFICIENCY CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

YES NO If "Yes," describe impact of each of the Veteran's nutritional deficiency condition(s), providing one or more examples:

SECTION VII - REMARKS

7A. 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: