



RESPIRATORY CONDITIONS (OTHER THAN TUBERCULOSIS AND SLEEP APNEA) 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:

[Empty text box for describing other requestor]

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?

[Empty text box for describing examination method]

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.

[Large empty text box for identifying evidence reviewed]

SECTION II - MEDICAL HISTORY

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

2B. DOES THE VETERAN'S RESPIRATORY CONDITION REQUIRE THE USE OF ORAL OR PARENTERAL CORTICOSTEROID MEDICATIONS?

- YES NO (If "Yes," complete the following):
 - Requires chronic low dose (maintenance) corticosteroids
 - Requires intermittent courses or bursts of systemic (oral or parenteral) corticosteroids
(If checked, indicate number of courses or bursts in past 12 months):
 0 1 2 3 4 or more
 - Requires systemic (oral or parenteral) high dose (therapeutic) corticosteroids for control
 - Requires daily use of systemic (oral or parenteral) high dose corticosteroids
 - Requires daily use of systemic (oral or parenteral) immuno-suppressive medications
 - Other, describe: _____

(If the veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the need for corticosteroids or immuno-suppressive medications): _____

2C. DOES THE VETERAN'S RESPIRATORY CONDITION REQUIRE THE USE OF INHALED MEDICATIONS?

- YES NO (If "Yes," check all that apply):
 - Inhalational bronchodilator therapy
(If "Yes," indicate frequency): Intermittent Daily
 - Inhalational anti-inflammatory medication
(If "Yes," indicate frequency): Intermittent Daily
 - Other inhaled medications, describe: _____

(If the veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the need for inhaled medications): _____

2D. DOES THE VETERAN'S RESPIRATORY CONDITION REQUIRE THE USE OF ORAL BRONCHODILATORS?

- YES NO
(If "Yes," indicate frequency): Intermittent Daily

2E. DOES THE VETERAN'S RESPIRATORY CONDITION REQUIRE THE USE OF ANTIBIOTICS?

- YES NO
(If "Yes," list antibiotics, dose, frequency and condition for which antibiotics are prescribed): _____

2F. DOES THE VETERAN REQUIRE OUTPATIENT OXYGEN THERAPY FOR HIS OR HER RESPIRATORY CONDITION?

- YES NO
(If "Yes," does the veteran require continuous oxygen therapy (>17 hours/day?):

- YES NO
(If the veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the requirement for oxygen therapy): _____

SECTION III - PULMONARY CONDITIONS

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING PULMONARY CONDITIONS?

- YES NO (If "No," proceed to Section IV) (If "Yes," check all that apply):
 - Asthma (If checked, complete Part A below)
 - Bronchiectasis (If checked, complete Part B below)
 - Sarcoidosis (If checked, complete Part C below)
 - Pulmonary embolism and related diseases (If checked, complete Part D below)
 - Bacterial lung infection (If checked, complete Part E below)
 - Mycotic lung infection (If checked, complete Part F below)
 - Pneumothorax (If checked, complete Part G below)
 - Gunshot/fragment wound (If checked, complete Part H below)
 - Cardiopulmonary complications (If checked, complete Part I below)
 - Respiratory failure (If checked, complete Part J below)
 - Tumors or neoplasms (If checked, complete Part K below)

- Other pulmonary conditions, pertinent physical findings or scars due to pulmonary conditions: _____
(If checked, complete Part L below)

SECTION III - PULMONARY CONDITIONS (Continued)

PART A - ASTHMA

1A. HAS THE VETERAN HAD ANY ASTHMA ATTACKS WITH EPISODES OF RESPIRATORY FAILURE IN THE PAST 12 MONTHS?

- YES NO (If "Yes," indicate average number of asthma attacks with episodes of respiratory failure per week in past 12 months): 0 1 2 3 4 or more

1B. HAS THE VETERAN HAD ANY PHYSICIAN VISITS FOR REQUIRED CARE OF EXACERBATIONS?

- YES NO (If "Yes," describe frequency and severity of exacerbations): (Indicate frequency of physician visits for required care of exacerbations over past 12 months): Less frequently than monthly At least monthly

PART B - BRONCHIECTASIS

2A. INDICATE ANY FINDINGS, SIGNS AND SYMPTOMS THAT ARE ATTRIBUTABLE TO BRONCHIECTASIS:

- Productive cough (If checked, indicate frequency and severity of productive cough (check all that apply)): Intermittent Daily Near constant Purulent sputum at times Blood-tinged sputum at times Other, describe: Acute infection (If checked, indicate number of infections requiring a prolonged course of antibiotics (lasting 4 to 6 weeks) in the past 12 months): 0 1 2 3 4 or more Requiring a course of antibiotics at least twice a year Requiring a prolonged course of antibiotics (lasting 4 to 6 weeks) more than twice a year Requiring antibiotic usage almost continuously Anorexia (If checked, describe): Weight loss (If checked, provide baseline weight: and current weight:) (Note - For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease) Frank hemoptysis (If checked, describe): Other, describe:

2B. HAS THE VETERAN HAD ANY INCAPACITATING EPISODES OF INFECTION DUE TO BRONCHIECTASIS?

- (NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician) YES NO (If "Yes," indicate total duration of incapacitating episodes of infection in past 12 months): 0 to no more than 2 weeks 2 to no more than 4 weeks 4 to no more than 6 weeks At least 6 weeks or more

PART C - SCARCOIDOSIS

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

- YES NO (If, "Yes," check all that apply): No physiologic impairment No symptoms Persistent symptoms (If checked, describe): Chronic hilar adenopathy Stable lung infiltrates Pulmonary involvement Progressive pulmonary disease (If checked, describe): Cardiac involvement with congestive heart failure Fever (If checked, describe): Night sweats (If checked, describe): Weight loss (If checked, provide baseline weight: and current weight:) (NOTE: For VA purposes, baseline weight is the average weight for a 2-year period preceding onset of disease) Other, describe:

PART C - SARCOIDOSIS (Continued)

3B. INDICATE STAGE DIAGNOSED BY X-RAY FINDINGS:

- Stage 1: Bihilar lymphadenopathy
- Stage 2: Bihilar lymphadenopathy and reticulonodular infiltrates
- Stage 3: Bilateral pulmonary infiltrates
- Stage 4: Fibrocystic sarcoidosis typically with upward hilar retraction, cystic and bullous changes

3C. DOES THE VETERAN HAVE OPHTHALMOLOGIC, RENAL, CARDIAC, NEUROLOGIC, OR OTHER ORGAN SYSTEM INVOLVEMENT DUE TO SARCOIDOSIS?

- YES NO (If "Yes," also complete appropriate additional Questionnaires)

PART D - PULMONARY EMBOLISM AND RELATED DISEASES

4. SELECT THE STATEMENT(S) THAT BEST DESCRIBE THE VETERAN'S PULMONARY VASCULAR DISEASE OR PULMONARY EMBOLISM CONDITION (Check all that apply):

- Asymptomatic, following resolution of pulmonary thromboembolism
- Symptomatic, following resolution of acute pulmonary embolism
- Chronic pulmonary thromboembolism requiring anticoagulant therapy
- Following inferior vena cava surgery
- Chronic pulmonary thromboembolism
- Pulmonary hypertension secondary to other obstructive disease of pulmonary arteries or veins
- Other, describe: _____

PART E - BACTERIAL LUNG INFECTION

5A. IDENTIFY TYPE OF BACTERIAL LUNG INFECTION:

- Actinomycosis Nocardiosis Chronic lung abscess Other, describe: _____

5B. INDICATE CURRENT STATUS OF THE VETERAN'S BACTERIAL INFECTION OF THE LUNG

- ACTIVE INACTIVE

5C. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS AND SYMPTOMS ATTRIBUTABLE TO A BACTERIAL INFECTION OF THE LUNG OR CHRONIC LUNG ABSCESS?

- YES NO (If "Yes," check all that apply):
 - Fever
 - Night sweats
 - Weight loss (If checked, provide baseline weight: _____ and current weight: _____)
(NOTE: For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)
 - Hemoptysis
 - Other, describe: _____

PART F - MYCOTIC LUNG DISEASES

6. INDICATE STATUS OF MYCOTIC LUNG DISEASE (including histoplasmosis of lung, coccidioidomycosis, blastomycosis, cryptococcosis, aspergillosis, or mucormycosis) (Check all that apply):

- No symptoms
- Chronic pulmonary mycosis
- Healed and inactive mycotic lesions
- Occasional productive cough
- Occasional minor hemoptysis
- Requires suppressive therapy
- Fever
- Night sweats
- Weight loss (If checked, provide baseline weight: _____ and current weight: _____)
(NOTE: For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)
- Massive hemoptysis
- Other, describe: _____

PART G - PNEUMOTHORAX

7. INDICATE THE TYPE OF PNEUMOTHORAX, TREATMENT AND RESIDUAL CONDITIONS, IF ANY (Check all that apply):

- Spontaneous total pneumothorax
- Spontaneous partial pneumothorax
- Traumatic total pneumothorax
- Traumatic partial pneumothorax
- Resulting in hospitalization (If checked, provide date of hospital admission _____ and date of discharge _____)
- Resulting in residual conditions (If checked, describe): _____
- Other, describe: _____

SECTION III - PULMONARY CONDITIONS (Continued)

PART H - GUNSHOT/FRAGMENT WOUND

8. SELECT THE STATEMENT(S) THAT BEST DESCRIBE THE VETERAN'S GUNSHOT OR FRAGMENT WOUND OR THE PLEURAL CAVITY AND RESIDUALS, IF ANY (Check all that apply):

- Bullet or missile retained in lung
- Pain or discomfort on exertion
- Scattered rales
- Some limitation of excursion of diaphragm or of lower chest expansion
- Other, describe: _____

NOTE: If any muscles (other than those which control respiration) are affected by this injury, also complete a Muscle Injuries Questionnaire

PART I - CARDIOPULMONARY COMPLICATIONS

9A. DOES THE VETERAN'S RESPIRATORY CONDITION RESULT IN CARDIOPULMONARY COMPLICATIONS SUCH AS COR PULMONALE, RIGHT VENTRICULAR HYPERTROPHY OR PULMONARY HYPERTENSION?

- YES NO (If "Yes," check all that apply):
- Cor pulmonale (right heart failure)
 - Right ventricular hypertrophy
 - Pulmonary hypertension (shown by echocardiogram or cardiac catheterization; report test results in Diagnostic Testing Section)
 - Other, describe: _____

9B. IF THE VETERAN HAS MORE THAN ONE RESPIRATORY CONDITION, INDICATE WHICH CONDITION IS PREDOMINANTLY RESPONSIBLE FOR THE CARDIOPULMONARY COMPLICATIONS:

PART J - RESPIRATORY FAILURE

10A. PROVIDE DATES AND DESCRIBE THE VETERAN'S EPISODES OF ACUTE RESPIRATORY FAILURE:

10B. IF THE VETERAN HAS MORE THAN ONE RESPIRATORY CONDITION, INDICATE WHICH CONDITION IS PREDOMINANTLY RESPONSIBLE FOR THE EPISODES OF RESPIRATORY FAILURE:

PART K - TUMORS AND NEOPLASMS

11A. 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 section)

11B. IS THE NEOPLASM:

- BENIGN MALIGNANT

(If malignant, indicate status of disease)

Active

- Surgery, describe _____
- Antineoplastic chemotherapy
- Radiation
- Other, describe _____

Anticipated date of final treatment (surgical, antineoplastic, chemotherapy, or other) _____

Remission

- Surgery, describe _____
- Antineoplastic chemotherapy
- Radiation
- Other, describe _____

Date of final treatment (surgical, antineoplastic, chemotherapy, or other) _____

11C. 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):

11D. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DESCRIBE USING THE ABOVE FORMAT:

PART L - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

12A. 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*):

12B. 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.

3. COMMENTS, IF ANY:

SECTION IV - DIAGNOSTIC TESTING

NOTE: If diagnostic test results are in the medical record and reflect the veteran's current respiratory condition, repeat testing is not required.

4A. HAVE IMAGING STUDIES OR PROCEDURES BEEN PERFORMED? (*For VA purposes, imaging studies are not required for many respiratory conditions*)

YES NO (*If "Yes," check all that apply*):

- | | | |
|---|-------------|----------------|
| <input type="checkbox"/> Chest x-ray | Date: _____ | Results: _____ |
| <input type="checkbox"/> Magnetic resonance imaging (<i>MRI</i>) | Date: _____ | Results: _____ |
| <input type="checkbox"/> Computed tomography (<i>CT</i>) | Date: _____ | Results: _____ |
| <input type="checkbox"/> High resolution computed tomography to evaluate interstitial lung disease such as asbestosis (<i>HRCT</i>) | Date: _____ | Results: _____ |
| <input type="checkbox"/> Bronchoscopy | Date: _____ | Results: _____ |
| <input type="checkbox"/> Biopsy | Date: _____ | Results: _____ |
| <input type="checkbox"/> Other, describe: _____ | Date: _____ | Results: _____ |

4B. HAS PULMONARY FUNCTION TESTING (PFT) BEEN PERFORMED?

YES NO

(*If "Yes," do PFT results reported below reflect the veteran's current pulmonary function?*)

YES NO

MOST RESPIRATORY CONDITIONS REQUIRE PULMONARY FUNCTION TESTING, SINCE PFT RESULTS REPRESENT A MAJOR BASIS FOR THEIR EVALUATION. HOWEVER, PULMONARY FUNCTION TESTING IS NOT REQUIRED IN ALL INSTANCES. FOR VA PURPOSES, IF THE VETERAN HAS ANY OF THE FOLLOWING CONDITIONS, PFTs ARE NOT REQUIRED. IF PFTs HAVE NOT BEEN COMPLETED, INDICATE REASON:

- Veteran requires outpatient oxygen therapy
- Veteran has had 1 or more episodes of acute respiratory failure
- Veteran has been diagnosed with cor pulmonale, right ventricular hypertrophy or pulmonary hypertension
- Veteran has had exercise capacity testing and results are 20 ml/kg/min or less
- Other, describe: _____

4C. PFT RESULTS:

Date of test: _____

Pre-bronchodilator:

- FVC: _____ % predicted
- FEV-1: _____ % predicted
- FEV-1/FVC: _____ %
- DLCO: _____ % predicted

Post-bronchodilator, if indicated:

- FVC: _____ % predicted
- FEV-1: _____ % predicted
- FEV-1/FVC: _____ %

SECTION IV - DIAGNOSTIC TESTING (Continued)

4D. WHICH TEST RESULT MOST ACCURATELY REFLECTS THE VETERAN'S LEVEL OF DISABILITY (Based on the condition that is being evaluated for this report)? THIS QUESTION IS IMPORTANT FOR VA PURPOSES.

- FVC % predicted FEV-1/FVC
 FEV-1 % predicted DLCO

4E. IF POST-BRONCHODILATOR TESTING HAS NOT BEEN COMPLETED, INDICATE REASON:

- Pre-bronchodilator results are normal
 Not indicated for veteran's condition
 Not indicated in veteran's particular case (If checked, provide reason): _____
 Other, describe: _____

4F. IF DIFFUSION CAPACITY OF THE LUNG FOR CARBON MONOXIDE BY THE SINGLE BREATH METHOD (DLCO) TESTING HAS NOT BEEN COMPLETED, PROVIDE REASON:

- Not indicated for veteran's condition
 Not indicated in veteran's particular case
 Not valid for veteran's particular case
 Other, describe: _____

4G. DOES THE VETERAN HAVE MULTIPLE RESPIRATORY CONDITIONS?

- YES NO

(If "Yes," list conditions and indicate which condition is predominantly responsible for the limitation in pulmonary function, if any limitation is present):

4H. HAS EXERCISE CAPACITY TESTING BEEN PERFORMED?

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

- Maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation)
 Maximum oxygen consumption of 15-20 ml/kg/min (with cardiorespiratory limit)

4I. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

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

SECTION V - FUNCTIONAL IMPACT

5. DOES THE VETERAN'S RESPIRATORY CONDITION IMPACT HIS OR HER ABILITY TO WORK?

- YES NO (If "Yes," describe impact of each of the veteran's respiratory conditions, providing one or more examples):

SECTION VI - REMARKS

6. REMARKS (If any)

SECTION VII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

7A. Examiner's signature:

7B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

7C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

7D. Date Signed:

7E. Examiner's phone/fax numbers:

7F. National Provider Identifier (NPI) number:

7G. Medical license number and state:

7H. Examiner's address: