



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 HAD A DISORDER OF THE BREAST(S)?

YES  NO

1B. IF YES, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO THE BREAST(S)

| DIAGNOSIS # 1 - | ICD CODE - | DATE OF DIAGNOSIS - |
|-----------------|------------|---------------------|
| DIAGNOSIS # 2 - | ICD CODE - | DATE OF DIAGNOSIS - |
| DIAGNOSIS # 3 - | ICD CODE - | DATE OF DIAGNOSIS - |

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO THE BREAST(S), LIST USING ABOVE FORMAT:

**SECTION II - MEDICAL HISTORY**

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

2B. DOES THE VETERAN HAVE, OR HAVE A HISTORY, OF A NEOPLASM OF THE BREAST?

YES  NO

2C. IF YES, IS OR WAS THERE A MALIGNANT NEOPLASM OF THE BREAST?

YES  NO (*If "Yes," indicate which breast*):  RIGHT  LEFT  BOTH

(*If "Yes," is the malignancy active?*):  YES  NO, WATCHFUL WAITING

(*If "Yes," were there or are there currently any metastases?*):  YES  NO

(*If "Yes," describe locations*): \_\_\_\_\_

2D. IF YES, IS OR WAS THERE A BENIGN NEOPLASM?

YES  NO

(*If "Yes," indicate which breast*):  RIGHT  LEFT  BOTH

**SECTION III - TREATMENT/SURGERY**

3A. HAS THE VETERAN COMPLETED ANY TYPE OF TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM AND/OR METASTASES?

YES  NO; WATCHFUL WAITING

(*If "Yes," indicate treatment type(s) - check all that apply*):

- Treatment completed; currently in watchful waiting status
- Undergoing surgical, X-Ray, antiseptic chemotherapy or other therapeutic procedure

Surgery If checked, describe: \_\_\_\_\_  
Date(s) of surgery: \_\_\_\_\_

Radiation therapy  
Date of most recent treatment: \_\_\_\_\_  
Date of completion of treatment or anticipated date of completion: \_\_\_\_\_  
Side  RIGHT  LEFT  BOTH

Antineoplastic chemotherapy  
Date of most recent treatment: \_\_\_\_\_  
Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

Other therapeutic procedure and/or treatment (*describe*): \_\_\_\_\_  
Date of procedure: \_\_\_\_\_  
Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

Describe the other treatment and/or procedure:

**SECTION III - TREATMENT/SURGERY (Continued)**

3B. HAS THE VETERAN UNDERGONE BREAST SURGERY?

YES  NO

(If "Yes," indicate procedure type and severity (check all that apply)):

Wide local excision (For VA purposes, wide local excision means removal of a portion of the breast tissue and includes partial mastectomy, lumpectomy, tylectomy, segmentectomy, and quadrantectomy)

Significant alteration of form  Right  Left  Both  
 Significant alteration of size  Right  Left  Both  
 Without significant alteration of form  Right  Left  Both  
 Without significant alteration of size  Right  Left  Both

Simple (or total) mastectomy (For VA purposes, a simple (or total) mastectomy means removal of all of the breast tissue, nipple, and a small portion of the overlying skin, but lymph nodes and muscles are left intact)

Significant alteration of form  Right  Left  Both  
 Significant alteration of size  Right  Left  Both

Modified radical mastectomy (For VA purposes, a modified radical mastectomy means removal of the entire breast and axillary lymph nodes, in continuity with the breast, with pectoral muscles left intact)

Right  Left  Both

Radical mastectomy (For VA purposes, radical mastectomy means removal of the entire breast, underlying pectoral muscles, and regional lymph nodes up to the coracoclavicular ligament)

Right  Left  Both

Axillary or sentinel lymph node excision

Right  Left  Both

Significant alteration of size or form

Right  Left  Both

Biopsy

Right  Left  Both

Other: \_\_\_\_\_

Right  Left  Both

3C. ARE THERE ANY RESIDUAL CONDITIONS CAUSED BY THE BENIGN OR MALIGNANT NEOPLASM OR ITS TREATMENT (e.g., arm swelling, nerve damage to arm)?

YES  NO

(If "Yes," briefly describe the conditions and complete appropriate Questionnaire):

**SECTION IV - OBJECTIVE FINDINGS AND RESIDUALS**

4. DID THE SURGERY OR RADIATION TREATMENT RESULT IN THE LOSS OF 25 PERCENT OR MORE TISSUE FROM A SINGLE BREAST OR BOTH BREASTS IN COMBINATION?

YES  NO

**SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS**

5A. 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):

5B. 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)

**SECTION VI - DIAGNOSTIC TESTING**

**NOTE -** If imaging and/or diagnostic test results are in the medical record and reflect the Veteran's current condition, repeat testing is not required.

6. HAS THE VETERAN HAD IMAGING AND/OR DIAGNOSTIC TESTING AND IF SO, ARE THERE SIGNIFICANT FINDINGS AND/OR RESULTS?

YES  NO

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

**SECTION VII - FUNCTIONAL IMPACT**

7. DOES THE VETERAN'S BREAST CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

YES  NO *(If "Yes," describe the impact of each of the Veteran's breast conditions, providing one or more examples)*

**SECTION VIII - REMARKS**

8. REMARKS *(If any)*

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

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

9A. Examiner's signature:

9B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

9C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

9D. Date Signed:

9E. Examiner's phone/fax numbers:

9F. National Provider Identifier (NPI) number:

9G. Medical license number and state:

9H. Examiner's address: