Department of Veterans Affairs

FIBROMYALGIA DISABILITY BENEFITS QUESTIONNAIRE

Name of Claimant/Veteran:	Claimant/Veteran's Social Security Number:	Date of Examination:

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.

DOMINANT HAND

Dominant hand: ☐ Right ☐ Left ☐ Ambidextrous

SECTION I - DIAGNOSIS

Note: This is the condition for which an evaluation has been requested on an exam request form (internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. Does the Veteran have a current diagnosis of fibromyalgia? (Fibromyalgia may also be called fibrosytis or primary fibromyalgia syndrome)

☐ Yes ☐ No (If no, explain your findings and reasons):

Note: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in the remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis or an approximate date determined through record review or reported history.

SECTION I - DIAGNOSIS (continued)

1B. If yes, select the Veteran's condition (check all that apply) .

☐ Fibromyalgia ICD Code: _____ Date of diagnosis: _____

☐ 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 fibromyalgia, list using above format.

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's fibromyalgia condition (brief summary):

2B. Is continuous medication required for control of fibromyalgia symptoms?

☐ Yes ☐ No If yes, list only those medications required for the Veteran's fibromyalgia condition:

2C. Is the Veteran currently undergoing treatment for this condition?

☐ Yes ☐ No If yes, describe:

2D. Are the Veteran's fibromyalgia symptoms refractory to therapy?

☐ Yes ☐ No If yes, describe:

SECTION III - FINDINGS, SIGNS, AND SYMPTOMS

3A. Does the Veteran currently have any findings, signs, or symptoms attributable to fibromyalgia?

☐ Yes ☐ No If yes, complete the following (check all that apply):

☐ Widespread musculoskeletal pain (Note: For VA purposes, widespread musculoskeletal pain means that pain occurs in both sides of the body, both above and below the waist and affecting both the axial skeleton (i.e., cervical spine, anterior chest, thoracic spine or low back) and the extremities)

☐ Stiffness

☐ Muscle weakness (If checked, describe):

☐ Fatigue

☐ Sleep disturbances

☐ Paresthesias

☐ Headache

☐ Depression

☐ Anxiety

☐ Irritable bowel symptoms

☐ Raynaud's-like symptoms

☐ Other (If checked, describe): _____

For all checked conditions, describe:

SECTION III - FINDINGS, SIGNS, AND SYMPTOMS (continued)

Note: If Mental Health conditions, such as depression due to fibromyalgia are identified, a Mental Disorders Questionnaire must also be completed.

3B. Frequency of fibromyalgia symptoms (check all that apply):

- ☐ No symptoms
- ☐ Episodic with exacerbations
- ☐ Present more than one-third of the time
- ☐ Constant or nearly constant
- ☐ Often precipitated by environmental or emotional stress or overexertion (If checked, describe):

- ☐ Other (If checked, describe):

3C. Does the Veteran have tender points (trigger points) for pain present?

☐ Yes ☐ No If yes, complete the following (check all that apply):

☐	All bilaterally			
☐	Low cervical region: at anterior aspect of the interspaces between transverse processes of C5-C7 (If checked, indicate side):	☐ Left	☐ Right	☐ Both
☐	Second rib: at second costochondral junction (If checked, indicate side):	☐ Left	☐ Right	☐ Both
☐	Occiput: at suboccipital muscle insertion (If checked, indicate side):	☐ Left	☐ Right	☐ Both
☐	Trapezius muscle: midpoint of upper border (If checked, indicate side):	☐ Left	☐ Right	☐ Both
☐	Supraspinatus muscle: above medial border of the scapular spine (If checked, indicate side):	☐ Left	☐ Right	☐ Both
☐	Lateral epicondyle: 2 cm distal to lateral epicondyle (If checked, indicate side):	☐ Left	☐ Right	☐ Both
☐	Gluteal: at upper outer quadrant of buttocks (If checked, indicate side):	☐ Left	☐ Right	☐ Both
☐	Greater trochanter: posterior to greater trochanteric prominence (If checked, indicate side):	☐ Left	☐ Right	☐ Both
☐	Knee: medial joint line (If checked, indicate side):	☐ Left	☐ Right	☐ Both
☐	Other, specify: _____ (If checked, indicate side):	☐ Left	☐ Right	☐ Both

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 any conditions listed in the diagnosis section above?

☐ 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 above?

☐ Yes ☐ No If yes, also complete the appropriate dermatological questionnaire.

SECTION V - DIAGNOSTIC TESTING

Note - Imaging studies are not required to document fibromyalgia.

5A. Are there any significant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

☐ Yes ☐ No If yes, provide type of test or procedure, date, and results (brief summary):

SECTION VI - FUNCTIONAL IMPACT

Note**:** Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

6A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)? ☐ Yes ☐ No If yes, describe the functional impact of each condition, providing one or more examples:

SECTION VII- ASSISTIVE DEVICES

7A. Does the Veteran use any assistive devices? ☐ Yes ☐ No

If Yes, identify the assistive devices used. Check all that apply and indicate frequency.

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Brace(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutch(es)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

7B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

SECTION VIII - REMARKS

8A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

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: