Department of Veterans Affairs

SKIN DISEASES 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

1. DOES THE VETERAN HAVE A CURRENT SKIN CONDITION?

☐ YES ☐ NO

For Burn Conditions, the SCARS/DISFIGUREMENT DISABILITY BENEFITS QUESTIONNAIRE must be completed.

IF YES, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO SKIN CONDITIONS. INDICATE THE CATEGORY OF SKIN CONDITION, AND THEN PROVIDE SPECIFIC DIAGNOSIS IN THAT CATEGORY *(check all that apply):*

☐ Dermatitis or eczema
Diagnosis: ICD Code: _____ Date of diagnosis: _____

☐ Tumors and neoplasms of the skin, including malignant melanoma
Diagnosis: ICD Code: _____ Date of diagnosis: _____

☐ Dermatophytosis (ringworm: of body, tinea corporis; of head, tinea capitis; of feet, tinea pedis; of beard area, tinea barbae; of nails, tinea unguium (onychomycosis); of inguinal area (jock itch), tinea cruris; tinea versicolor)
Diagnosis: ICD Code: _____ Date of diagnosis: _____

☐ Acne ICD Code: _____ Date of diagnosis: _____

☐ Psoriasis ICD Code: _____ Date of diagnosis: _____

☐ Infectious skin conditions not listed elsewhere (including bacterial, fungal, viral, treponemal and parasitic skin conditions)
Diagnosis: ICD Code: _____ Date of diagnosis: _____

☐ Chronic Urticaria ICD Code: _____ Date of diagnosis: _____

☐ Alopecia
Diagnosis: ICD Code: _____ Date of diagnosis: _____

☐ Keratinization skin disorders (including icthyoses, Darier's disease, and palmoplantar keratoderma)
Diagnosis: ICD Code: _____ Date of diagnosis: _____

☐ Erythroderma (exfoliative dermatitis) ICD Code: _____ Date of diagnosis: _____

☐ Papulosquamous skin disorders not listed elsewhere (including lichen planus, large or small plaque parapsoriasis, pityriasis lichenoides et varioliformis acuta (PLEVA), lymphomatoid papulosus, mycosis fungoides and pityriasis rubra pilaris (PRP))
Diagnosis: ICD Code: _____ Date of diagnosis: _____

☐ Hyperhidrosis ICD Code: _____ Date of diagnosis: _____

☐ Vitiligo ICD Code: _____ Date of diagnosis: _____

☐ Bullous disorders (including pemphigus vulgaris, pemphigus foliaceous, bullous pemphigoid, dermatitis herpetiformis, epidermolysis bullosa acquisita, benign chronic familial pemphigus (Hailey-Hailey), and porphyria cutanea tarda)
Diagnosis: ICD Code: _____ Date of diagnosis: _____

☐ Cutaneous manifestations of collagen-vascular diseases not listed elsewhere (including scleroderma, calcinosis cutis, and dermatomyositis)
Diagnosis: ICD Code: _____ Date of diagnosis: _____

☐ Chloracne ICD Code: _____ Date of diagnosis: _____

☐ Discoid lupus or subacute cutaneous lupus erythematosus ICD Code: _____ Date of diagnosis: _____

☐ Erythema multiforme (toxic epidermal necrolysis) ICD Code: _____ Date of diagnosis: _____

☐ Primary cutaneous vasculitis ICD Code: _____ Date of diagnosis: _____

☐ Other skin condition

Other diagnosis #1: ICD Code: _____ Date of diagnosis: _____

Other diagnosis #2: ICD Code: _____ Date of diagnosis: _____

Other diagnosis #3: ICD Code: _____ Date of diagnosis: _____

SECTION II - MEDICAL HISTORY

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

2B. RESOLVED SKIN CONDITIONS - DID THE VETERAN PREVIOUSLY HAVE A SKIN CONDITION THAT IS NOW COMPLETELY RESOLVED AND NO LONGER REQUIRES TREATMENT OF ANY TYPE? *(brief summary):*

2C. COMMENTS, IF ANY:

SECTION III - TREATMENT

3A. HAS THE VETERAN BEEN TREATED WITH MEDICATION IN THE PAST 12 MONTHS FOR ANY SKIN CONDITION?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐ Corticosteroids or other immunosuppressive medications

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration): ☐ Oral ☐ Injection ☐ Intranasal ☐ Suppository ☐ Topical ☐ Other: _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Antihistamines

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration): ☐ Oral ☐ Injection ☐ Intranasal ☐ Suppository ☐ Topical ☐ Other: _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Retinoids

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration): ☐ Oral ☐ Injection ☐ Intranasal ☐ Suppository ☐ Topical ☐ Other: _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Sympathomimetics

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration): ☐ Oral ☐ Injection ☐ Intranasal ☐ Suppository ☐ Topical ☐ Other: _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Biologics

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration): ☐ Oral ☐ Injection ☐ Intranasal ☐ Suppository ☐ Topical ☐ Other: _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Other medication

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration): ☐ Oral ☐ Injection ☐ Intranasal ☐ Suppository ☐ Topical ☐ Other: _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Other medication

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration): ☐ Oral ☐ Injection ☐ Intranasal ☐ Suppository ☐ Topical ☐ Other: _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

NOTE: If a medication is used for more than one condition, provide names of all conditions, name of medication used for each condition, and frequency of use for each condition:

SECTION III - TREATMENT *(Continued)*

3B. HAS THE VETERAN HAD ANY TREATMENTS OR PROCEDURES OTHER THAN SYSTEMIC OR TOPICAL MEDICATIONS IN THE PAST 12 MONTHS FOR ANY SKIN CONDITION?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐ **Phototherapy such as ultraviolet-B light (UVB) treatment**

(If checked, date of most recent treatment):

(Specify condition treated): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ **Photochemotherapy (to include PUVA (psoralen with long wave ultraviolet A light)) treatment**

(If checked, date of most recent treatment):

(Specify condition treated): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ **Electron beam therapy**

(If checked, date of most recent treatment):

(Specify condition treated): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ **Intensive light therapy**

(If checked, date of most recent treatment):

(Specify condition treated): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ **Other treatment** ***(Specify treatment):*** _____

(If checked, date of most recent treatment):

(Specify condition treated): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ **Other treatment** ***(Specify treatment)*****:** _____

(If checked, date of most recent treatment):

(Specify condition treated): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

SECTION IV - PHYSICAL EXAM

4A. INDICATE THE VETERAN'S VISIBLE CHARACTERISTIC LESIONS DUE TO THE SKIN CONDITION(S); INDICATE THE APPROXIMATE TOTAL BODY AREA AND APPROXIMATE TOTAL ***EXPOSED*** BODY AREA *(face, neck and hands)* AFFECTED ON CURRENT EXAMINATION *(check all that apply):*

☐ Dermatitis	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
☐ Eczema	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
☐ Dermatophytosis	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
☐ Bullous disorders	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
☐ Cutaneous manifestations of collagen vascular disorders not listed elsewhere	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
☐ Psoriasis	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%

SECTION IV - PHYSICAL EAM *(Continued)*

Condition	Area					
☐ Infections of the skin not listed elsewhere	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
☐ Papulosquamous disorders not listed elsewhere	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
☐ Diseases of keratinization	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
☐ Discoid lupus erythematosus	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
☐ Other Indicate diagnosis:	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
☐ Other Indicate diagnosis:	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
☐ Other Indicate diagnosis:	Total body area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%
	EXPOSED area	☐ None	☐ <5%	☐ 5% to <20%	☐ 20% to 40%	☐ >40%

Does the Veteran have a skin condition currently without any visible characteristic lesions at the time of the examination?

☐ YES ☐ NO

4B. FOR EACH SKIN CONDITION CHECKED IN ITEM 4A, GIVE SPECIFIC DIAGNOSIS AND DESCRIBE APPEARANCE AND LOCATION:

SECTION V - SPECIFIC SKIN CONDITIONS

5. INDICATE THE VETERAN'S SPECIFIC SKIN CONDITIONS AND COMPLETE ALL APPLICABLE SUBSEQUENT QUESTIONS *(check all that apply)*:

☐ Acne

(If checked, indicate severity and location (check all that apply)):

- ☐ Superficial acne (comedones, papules, pustules) of any extent
- ☐ Deep acne (deep inflamed nodules and pus-filled cysts)
  - ☐ Affects less than 40% of face and neck
  - ☐ Affects 40% or more of face and neck
  - ☐ Affects body areas other than face and neck

☐ Chloracne

(If checked, indicate severity and location (check all that apply)):

- ☐ Superficial acne (comedones, papules, pustules) of any extent
- ☐ Deep acne (deep inflamed nodules and pus-filled cysts)
  - ☐ Affects less than 40% of face and neck
  - ☐ Affects 40% or more of face and neck
  - ☐ Affects intertriginous areas (axilla of the arm, anogenital region, skin folds of the breasts, or between digits)
  - ☐ Affects non-intertriginous body areas other than face and neck

☐ Vitiligo

(If checked, indicate areas affected by vitiligo):

- ☐ Exposed areas affected
- ☐ No exposed areas affected

☐ Scarring alopecia

(If checked, indicate percent of scalp affected):

☐ <20% ☐ 20% to 40% ☐ >40%

☐ Alopecia areata

(If checked, indicate amount of hair loss):

☐ Hair loss limited to scalp and face ☐ Loss of all body hair ☐ Other, describe: ______________________

SECTION V - SPECIFIC SKIN CONDITIONS *(Continued)*

☐ Hyperhidrosis

(If checked, indicate severity):

☐ Able to handle paper or tools after treatment ☐ Unresponsive to treatment; unable to handle paper or tools

☐ Urticaria, chronic

Has the Veteran ever had a break in treatment? ☐ YES ☐ NO

If "Yes," did he/she experience symptoms at least twice a week for six weeks or more? ☐ YES ☐ NO

Indicate the type of treatment the Veteran is currently receiving:

☐ First line treatment
- ☐ Antihistamines
- ☐ Other:

☐ Second line treatment
- ☐ Corticosteroids
- ☐ Sympathomimetics
- ☐ Leukotriene inhibitors
- ☐ Neutrophil inhibitors
- ☐ Thyroid hormone
- ☐ Other:

☐ Third line treatment
- ☐ Plasmapheresis
- ☐ Immunotherapy
- ☐ Immunosuppressives
- ☐ Other:

☐ Vasculitis, primary cutaneous

Frequency of documented, vasculitis episodes occurring over the past 12 months:

☐ None
☐ 1 to 3
☐ 4 or more

Has the Veteran required the use of systemic immunosuppressive therapy over the past 12 months? ☐ YES ☐ NO

If "Yes," check the applicable frequency:

☐ Intermittent
☐ Continuous

Has the Veteran continued to have vasculitis episodes despite continuous systemic immunosuppressive therapy over the past 12 months? ☐ YES ☐ NO

☐ Erythroderma (exfoliative dermatitis)

(If checked, is there erythroderma/exfoliative dermatitis with any extent of involvement of the skin?

☐ YES ☐ NO

(If yes, check all that apply):

☐ Generalized involvement of the skin with systemic manifestations (such as fever, weight loss, or hypoproteinemia)
☐ Generalized involvement of the skin without systemic manifestations
☐ No current treatment due to a documented history of treatment failure with 2 or more treatment regimens
☐ No current treatment due to a documented history of treatment failure with 1 treatment regimen

NOTE: Treatment failure is defined as either disease progression, or less than a 25 percent reduction in the extent and severity of disease after four weeks of prescribed therapy, as documented by medical records.

☐ Erythema multiforme; toxic epidermal necrolysis

(If checked, indicate severity and frequency):

☐ Mucosal involvement
- ☐ Impairing mastication ☐ Not impairing mastication
- ☐ Without recurrent episodes ☐ One to three episodes over the past 12-month period
- ☐ Four or more episodes over the past 12-month period

SECTION V - SPECIFIC SKIN CONDITIONS *(Continued)*

☐ Palmar involvement
- ☐ Impairing use of hands ☐ Not impairing use of hands
- ☐ Without recurrent episodes ☐ One to three episodes over the past 12-month period
- ☐ Four or more episodes over the past 12-month period

☐ Plantar involvement
- ☐ Impairing ambulation ☐ Not impairing ambulation
- ☐ Without recurrent episodes ☐ One to three episodes over the past 12-month period
- ☐ Four or more episodes over the past 12-month period

Indicate the type of treatment the Veteran is currently receiving:
- ☐ Ongoing immunosuppressive therapy
- ☐ Intermittent systemic therapy (immunosuppressives, antihistamines, or sympathomimetics)
- ☐ Continuous systemic medication for control

☐ Veteran does not have any of the specific skin conditions listed above.

SECTION VI - TUMORS AND NEOPLASMS

6A. 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 items 6B through 6D)*

6B. 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):

_____

6C.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): _____

6D.IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION, DESCRIBE USING THE ABOVE FORMAT:

SECTION VII - SCARRING AND DISFIGUREMENT

7. DO ANY OF THE VETERAN'S SKIN CONDITIONS CAUSE SCARRING (REGARDLESS OF LOCATION), OR DISFIGUREMENT OF THE HEAD, FACE OR NECK?

☐ YES ☐ NO *(If "Yes," complete the Scars/Disfigurement DBQ).*

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

8A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO *(If "Yes," describe and complete the appropriate DBQ):*

8B. COMMENTS, IF ANY:

SECTION IX - FUNCTIONAL IMPACT

9. DO ANY OF THE VETERAN'S SKIN CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

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

SECTION X - REMARKS

10. REMARKS *(If any):*

SECTION XI - EXAMINER'S CERTIFICATION AND SIGNATURE

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

11A. Examiner's signature:

11B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

11C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

11D. Date Signed:

11E. Examiner's phone/fax numbers:

11F. National Provider Identifier (NPI) number:

11G. Medical license number and state:

11H. Examiner's address: