Department of Veterans Affairs

SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) AND OTHER AUTOIMMUNE 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

1A. DOES THE VETERAN HAVE A SYSTEMIC OR LOCALIZED AUTOIMMUNE DISEASE, INCLUDING SYSTEMIC LUPUS ERYTHEMATOSUS *(SLE)*? *(This is the condition the Veteran is claiming or for which an exam has been requested)*

☐ YES ☐ NO

1B. IF YES, SELECT THE VETERAN'S CONDITION:

☐ Autoimmune polyglandular syndrome ICD Code: _____ Date of diagnosis: _____
(If this condition affects multiple endocrine glands, ALSO complete appropriate questionnaire(s) for those conditions)

☐ Diabetes Mellitus Type I ICD Code: _____ Date of diagnosis: _____
(If checked, complete Diabetes Questionnaire in lieu of this questionnaire)

☐ Discoid lupus erythematosus ICD Code: _____ Date of diagnosis: _____
(If checked, ALSO complete Skin Diseases Questionnaire)

☐ Goodpasture's syndrome ICD Code: _____ Date of diagnosis: _____
(If this condition affects the lungs or kidneys, ALSO complete appropriate questionnaire(s) for those conditions)

☐ Guillain-Barre syndrome ICD Code: _____ Date of diagnosis: _____
(If this condition affects the nervous system, ALSO complete appropriate questionnaire(s) for those conditions)

☐ Polymyalgia rheumatica ICD Code: _____ Date of diagnosis: _____
(If this condition affects large muscle groups, ALSO complete appropriate questionnaire(s) for those conditions)

☐ Rheumatoid arthritis (RA) and Juvenile RA (JRA) ICD Code: _____ Date of diagnosis: _____
(If this condition affects the joints, lungs or skin, ALSO complete the appropriate questionnaire(s) for those conditions)

☐ Scleroderma ICD Code: _____ Date of diagnosis: _____
(If this condition affects the skin, lungs or intestines, ALSO complete the appropriate questionnaire(s) for those conditions)

☐ Sjögren's syndrome ICD Code: _____ Date of diagnosis: _____
(If this condition affects the salivary glands, lacrimal glands, joints or kidneys, ALSO complete the appropriate questionnaire(s) for those conditions)

☐ Subacute cutaneous lupus erythematosus ICD Code: _____ Date of diagnosis: _____

☐ Systemic lupus erythematosus ICD Code: _____ Date of diagnosis: _____

☐ Temporal arteritis/Giant cell arteritis ICD Code: _____ Date of diagnosis: _____

☐ Wegener's granulomatosis ICD Code: _____ Date of diagnosis: _____
(If this condition affects the blood vessels, sinuses, lungs or kidneys, ALSO complete the appropriate questionnaire(s) for those conditions)

☐ 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 AUTOIMMUNE DISEASES, LIST USING ABOVE FORMAT:

For all checked diagnoses, ALSO complete additional DBQ's as appropriate to fully describe effects of the condition.
If the Veteran has been diagnosed with HIV, complete the HIV Questionnaire in lieu of this questionnaire.
If the Veteran has been diagnosed with Diabetes Mellitus Type I, complete the Diabetes Questionnaire in lieu of this questionnaire.

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S AUTOIMMUNE DISEASE, INCLUDING SLE *(brief summary)*:

2B. OVER THE PAST 12 MONTHS, HAS THE VETERAN'S TREATMENT PLAN INCLUDED ORAL OR TOPICAL MEDICATIONS FOR ANY AUTOIMMUNE DISEASE OR AUTOIMMUNE DISORDER-RELATED SKIN CONDITION, INCLUDING SYSTEMIC, CUTANEOUS OR DISCOID LUPUS?

☐ YES ☐ NO

(If "Yes," check all that apply):

☐ Oral corticosteroids

(If checked, list medications):

_____

(Specify the condition medication is used for):

_____

Total duration of medication use in past 12 months?

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

SECTION II - MEDICAL HISTORY *(Continued)*

2B. OVER THE PAST 12 MONTHS, HAS THE VETERAN'S TREATMENT PLAN INCLUDED ORAL OR TOPICAL MEDICATIONS FOR ANY AUTOIMMUNE DISEASE OR AUTOIMMUNE DISORDER-RELATED SKIN CONDITION, INCLUDING SYSTEMIC, CUTANEOUS OR DISCOID LUPUS? ***(Continued)***

☐ Other immunosuppressive medications

(If checked, list medications):

(Specify the condition medication is used for):

Total duration of medication use in past 12 months?

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

☐ Immunosuppressive retinoids

(If checked, list medications):

(Specify the condition medication is used for):

Total duration of medication use in past 12 months?

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

☐ Topical corticosteroids

(If checked, list medications):

(Specify the condition medication is used for):

Total duration of medication use in past 12 months?

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

☐ Other oral or topical medications used for an autoimmune condition

(If checked, list medications):

(Specify the condition medication is used for):

Total duration of medication use in past 12 months?

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

2C. INDICATE STATUS OF THE VETERAN'S AUTOIMMUNE DISEASE, INCLUDING SLE:

☐ ACUTE
☐ CHRONIC
☐ OTHER *(describe):*

2D. DOES THE VETERAN HAVE EXACERBATIONS OF AN AUTOIMMUNE DISEASE, INCLUDING SLE?

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

Indicate average frequency of exacerbations per year:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ More than 3 exacerbations per year

Indicate average duration of symptoms during each exacerbation:

☐ Lasting less than one week
☐ Lasting a week or more
☐ Other *(describe):*

2E. DOES THE VETERAN'S AUTOIMMUNE DISEASE, INCLUDING SLE CURRENTLY PRODUCE SEVERE IMPAIRMENT OF HEALTH?

☐ YES ☐ NO *(If "Yes," describe the severe impairment of health):*

SECTION III - CUTANEOUS MANIFESTATIONS

3A. DOES THE VETERAN HAVE ANY CUTANEOUS MANIFESTATIONS OF AN AUTOIMMUNE DISEASE, INCLUDING SYSTEMIC, CUTANEOUS OR DISCOID LUPUS ERYTHEMATOSUS?

☐ YES ☐ NO *(If "Yes," complete the following section):*

3B. Specify the cutaneous manifestations *(check all that apply):*

☐ Discoid lupus erythematosus
☐ Subacute cutaneous lupus erythematosus
☐ Other, describe: _____

3C. Indicate areas affected by cutaneous manifestations *(check all that apply):*

☐ Malar rash over bridge of nose and bilateral cheeks, sparing nasolabial folds
☐ Cheeks *(If checked, specify which side):* ☐ Right ☐ Left ☐ Both
☐ Ears *(If checked, specify which side):* ☐ Right ☐ Left ☐ Both
☐ Nose
☐ Chin
☐ Lips and mouth, causing ulcers and scaling
☐ Other body areas, specify location: _____
☐ Hands
☐ Feet
☐ Scalp, causing scarring alopecia

Note: *For all checked boxes, describe cutaneous manifestations:*

_____

3D. Indicate approximate TOTAL body area affected by cutaneous manifestations of an autoimmune disease on current examination:

☐ None ☐ < 5% ☐ 5% to < 20% ☐ 20% to 40% ☐ > 40%

3E. Indicate approximate total EXPOSED body area *(face, neck and hands)* affected by cutaneous manifestations of an autoimmune disease on current examination:

☐ None ☐ < 5% ☐ 5% to < 20% ☐ 20% to 40% ☐ > 40%

3F. Do the cutaneous manifestations of the autoimmune disease cause scarring alopecia?

☐ Yes ☐ No *(If "Yes," indicate percent of scalp affected):* ☐ < 20% ☐ 20% to 40% ☐ > 40%

3G. 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)

3H. COMMENTS, IF ANY:

SECTION IV - FINDINGS, SIGNS AND SYMPTOMS

4A. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS *(other than cutaneous manifestations)* ATTRIBUTABLE TO AN AUTOIMMUNE DISEASE, INCLUDING SLE?

☐ Yes ☐ No *(If "Yes," complete the following section):*

4B. Has the Veteran had any symptoms *(other than cutaneous manifestations)* attributable to an autoimmune disease, including SLE, in the past 2 years?

☐ Yes ☐ No

4C. Does the Veteran have arthritis attributable to an autoimmune disease, including SLE?

☐ Yes ☐ No *(If "Yes," list affected joints and describe effect of autoimmune disease on each joint (brief summary) and ALSO complete the appropriate questionnaire for each affected joint):*

4D. Does the Veteran have recurrent ulcers on oral mucous membranes attributable to an autoimmune disease, including SLE?

☐ Yes ☐ No

(If "Yes," do the recurrent ulcers result in impairment of mastication, a speech impairment or other signs or symptoms?)

☐ Yes ☐ No *(If "Yes," describe and ALSO complete the appropriate questionnaire):*

SECTION IV - FINDINGS, SIGNS AND SYMPTOMS *(Continued)*

4E. Does the Veteran have any hematologic or lymphatic manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

(If "Yes," check all that apply and ALSO complete the appropriate questionnaire):

- ☐ General adenopathy
- ☐ Splenomegaly
- ☐ Anemia
- ☐ Leukopenia *(usually lymphopenia, with < 1500 cells/uL)*
- ☐ Thrombocytopenia *(sometimes life-threatening autoimmune thrombocytopenia)*
- ☐ Other, describe: _____

4F. Does the Veteran have any pulmonary manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

(If "Yes," check all that apply and ALSO complete the appropriate questionnaire):

- ☐ Pulmonary emboli
- ☐ Pulmonary hypertension
- ☐ Shrinking lung syndrome
- ☐ Recurrent pleurisy, with or without pleural effusion
- ☐ Other, describe: _____

4G. Does the Veteran have any cardiac manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

(If "Yes," check all that apply and ALSO complete a Heart Questionnaire):

- ☐ Percardial effusion
- ☐ Myocarditis
- ☐ Coronary artery vasculitis
- ☐ Valvular involvement
- ☐ Libman-Sacks endocarditis
- ☐ Other, describe: _____

4H. Does the Veteran have any neurologic manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

(If "Yes," describe and ALSO complete the appropriate questionnaire):

4I. Does the Veteran have any renal manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

(If "Yes," check all that apply and ALSO complete the appropriate Kidney and/or Hypertension Questionnaire):

- ☐ Glomerular nephritis
- ☐ Membranoproliferative glomerulonephritis
- ☐ Proteinuria
- ☐ Hypertension
- ☐ Edema
- ☐ Other, describe: _____

4J. Does the Veteran have any obstetric manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No *(If "Yes," describe and ALSO complete the appropriate questionnaire):*

_____

4K. Does the Veteran have any gastrointestinal manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

(If "Yes," describe and ALSO complete the appropriate questionnaire):

4L. Does the Veteran have any vascular *(arterial or venous)* manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

(If "Yes," check all that apply and ALSO complete the Artery and Vein Questionnaire):

- ☐ Recurrent arterial thrombosis
- ☐ Recurrent venous thrombosis
- ☐ Other, describe: _____

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 OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

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

SECTION VI - DIAGNOSTIC TESTING

6A. IF IMAGING STUDIES, DIAGNOSTIC PROCEDURES OR LABORATORY TESTING HAS BEEN PERFORMED AND REFLECTS THE VETERAN'S CURRENT CONDITION, PROVIDE MOST RECENT RESULTS AND NO FURTHER STUDIES OR TESTING ARE REQUIRED FOR THIS EXAMINATION *(**NOTE:** When appropriate provide **most recent** results)*

6B. Have imaging studies been performed?

☐ YES ☐ NO

(If "Yes," check all that apply):

☐ Chest x-ray	Date: _____	Results: _____	
☐ Magnetic resonance imaging *(MRI)*	Date: _____	Results: _____	
☐ Computed tomography *(CT)*	Date: _____	Results: _____	
☐ Other, describe: _____	Date: _____	Results: _____	

6C. Has laboratory testing been performed?

☐ YES ☐ NO

(If "Yes," check all that apply):

☐ Hemoglobin *(gm/100ml)*	Date: _____	Results: _____
☐ Hematocrit	Date: _____	Results: _____
☐ Red blood cell *(RBC)* count	Date: _____	Results: _____
☐ White blood cell *(WBC)* count	Date: _____	Results: _____
☐ White blood cell differential count	Date: _____	Results: _____
☐ Platelet count	Date: _____	Results: _____
☐ Erythrocyte sedimentation rate *(ESR)*	Date: _____	Results: _____
☐ C-reactive protein *(CRP)*	Date: _____	Results: _____
☐ Antinuclear antibody *(ANA)* titer	Date: _____	Results: _____
☐ Anti-Ro Antibody	Date: _____	Results: _____
☐ Anti-Smith antibodies	Date: _____	Results: _____
☐ Anti-Ro double strand *(ds)* DNA	Date: _____	Results: _____
☐ Antiphospolipid	Date: _____	Results: _____
☐ Complement components *(C3 and C4)*	Date: _____	Results: _____
☐ BUN	Date: _____	Results: _____
☐ Creatinine	Date: _____	Results: _____
☐ Estimated glomerular filtration rate *(EGFR)*	Date: _____	Results: _____
☐ Other, specify: _____	Date: _____	Results: _____

6D. Has a urinalysis been performed?

☐ YES ☐ NO

(If "Yes," complete the following):

Date of most recent urinalysis: _____

Results:

Microalbumin: ☐ Not elevated ☐ Elevated to: _____

Protein: ☐ None ☐ Trace ☐ 1+ ☐ 2+ ☐ 3+

Glucose: ☐ None ☐ Trace ☐ 1+ ☐ 2+ ☐ 3+

Hyaline casts: ☐ None ☐ 1-5 hyaline casts per LPF ☐ Other, describe: _____

Granular casts: ☐ None ☐ 1-5 granular casts per LPF ☐ Other, describe: _____

Blood: ☐ None ☐ Trace blood and no RBCs per HPF ☐ Trace blood and 1-5 RBCs per HPF ☐ 1+ blood and 1-5 RBCs per HPF ☐ 1+ blood and 5-10 RBCs per HPF ☐ 2+ blood and 10-20 RBCs per HPF ☐ Other, describe: _____

6E. Are there any other significant diagnostic test findings and/or results?

☐ YES ☐ NO *(If "Yes," provide type of test or procedure, date and results (brief summary)):*

SECTION VII - FUNCTIONAL IMPACT

7A. DOES THE VETERAN'S AUTOIMMUNE DISEASE IMPACT HIS OR HER ABILITY TO WORK?

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

SECTION VIII - REMARKS

8A. 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: