Department of Veterans Affairs

ARTERY AND VEIN CONDITIONS (VASCULAR DISEASES INCLUDING VARICOSE VEINS) DISABILITY BENEFITS QUESTIONNAIRE

Name of Patient/Veteran:	Patient/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 completed questionnaires. **It is intended that this questionnaire will be completed by the Veteran's healthcare provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

☐ Veteran/Claimant

☐ Third party (please list name(s) of organization(s) or individual(s))

☐ 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: These are condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. List the claimed condition(s) that pertain to this questionnaire:

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(s), 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.

1B. Does the Veteran now have or has he or she ever had a vascular disease (arterial or venous)? ◯ Yes ◯ No

If yes, provide only diagnoses that pertain to vascular disease (arterial or venous):

☐ Varicose veins	ICD Code:	Date of diagnosis:
☐ Post-phlebitic syndrome (of any etiology)	ICD Code:	Date of diagnosis:
☐ Aneurysm, any large artery	ICD Code:	Date of diagnosis:
☐ Aortic aneurysm: ascending, thoracic or abdominal	ICD Code:	Date of diagnosis:
☐ Aneurysm of a small artery	ICD Code:	Date of diagnosis:
☐ Raynaud's disease (also known as primary Raynaud's)	ICD Code:	Date of diagnosis:
☐ Raynaud's syndrome (also known as secondary Raynaud's phenomenon or secondary Raynaud's)	ICD Code:	Date of diagnosis:
☐ Erythromelalgia	ICD Code:	Date of diagnosis:
☐ Angioneurotic edema	ICD Code:	Date of diagnosis:
☐ Thrombo-angitis obliterans (Buerger's disease)	ICD Code:	Date of diagnosis:
☐ Arteriovenous (AV) fistula, traumatic	ICD Code:	Date of diagnosis:
☐ Soft tissue sarcoma of vascular origin	ICD Code:	Date of diagnosis:
☐ Peripheral arterial disease	ICD Code:	Date of diagnosis:
☐ Syphilitic aortic aneurysm	ICD Code:	Date of diagnosis:

1C. If there are additional diagnoses that pertain to vascular diseases, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history, including onset and course, of the Veteran's vascular condition(s). Brief summary:

SECTION III - VARICOSE VEINS AND/OR POST- PHLEBITIC SYNDROME

3A. Does the Veteran have or has ever had varicose veins? ◯ Yes ◯ No

If yes, indicate extremity: Upper ◯ Right ◯ Left ◯ Both Lower ◯ Right ◯ Left ◯ Both

3B. Does the Veteran have or has ever had post-phlebitic syndrome of any etiology? ◯ Yes ◯ No

If yes, indicate extremity: Upper ◯ Right ◯ Left ◯ Both Lower ◯ Right ◯ Left ◯ Both

3C. Check all symptoms that apply and indicate extremity affected:

	Upper			Lower		
☐ Asymptomatic palpable varicose veins	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Asymptomatic visible varicose veins	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Aching in leg after prolonged standing				◯ Right	◯ Left	◯ Both
☐ Fatigue in leg after prolonged standing				◯ Right	◯ Left	◯ Both
☐ Aching in leg after prolonged walking				◯ Right	◯ Left	◯ Both
☐ Fatigue in leg after prolonged walking				◯ Right	◯ Left	◯ Both
☐ Symptoms relieved by elevation of extremity	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Symptoms relieved by compression hosiery	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Constant pain at rest	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both

3D. Check all findings and/or signs that apply and indicate extremity affected:

	Upper			Lower		
☐ Beginning stasis pigmentation	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Persistent stasis pigmentation	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Beginning eczema	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Eczema	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Persistent edema	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Intermittent edema of extremity	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Persistent edema that is incompletely relieved by elevation of extremity	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Massive board-like edema	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Intermittent ulceration	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Persistent ulceration	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both
☐ Persistent subcutaneous induration	◯ Right	◯ Left	◯ Both	◯ Right	◯ Left	◯ Both

SECTION IV - PERIPHERAL ARTERIAL DISEASE AND THROMBO-ANGIITIS OBLITERANS (BUERGER'S DISEASE)

4A. Has the Veteran ever been diagnosed with any of the following? Check all that apply: ◯ Yes ◯ No

- ☐ Peripheral arterial disease
- ☐ Thrombo-angiitis obliterans (Buerger's Disease)
- ☐ Other _____

If any of the above conditions are checked, answer questions 4B - 4D.

4B. Has the Veteran undergone surgery for any of the listed conditions? ◯ Yes ◯ No

If yes list type of surgery: Date of surgery:

4C. Has the Veteran undergone any procedure other than surgery for revascularization? ◯ Yes ◯ No

If yes list type of procedure: Date of procedure:

4D. Indicate severity of current signs and symptoms and indicate side of upper extremity affected. Check all that apply:

Note: Trophic changes include, but are not limited to, skin changes (thinning, atrophy, fissuring, ulceration, scarring, absence of hair) as well as nail changes (clubbing, deformities).

☐ Diminished upper extremity pulses	◯ Right	◯ Left	◯ Both
☐ Trophic changes	◯ Right	◯ Left	◯ Both
☐ Numbness and paresthesia at the tips of the fingers	◯ Right	◯ Left	◯ Both
☐ Pains in the hand during physical activity	◯ Right	◯ Left	◯ Both
☐ Deep ischemic ulcers	◯ Right	◯ Left	◯ Both
☐ Necrosis of the fingers	◯ Right	◯ Left	◯ Both
☐ Persistent coldness of the extremity	◯ Right	◯ Left	◯ Both

SECTION V - ANEURYSM, ANY LARGE ARTERY

5A. Has the Veteran ever been diagnosed with an aneurysm of any large artery other than aorta? ◯ Yes ◯ No

If yes, is it symptomatic? ◯ Yes ◯ No

If a large aneurysm has been diagnosed, has the Veteran had a surgical procedure for the aneurysm? ◯ Yes ◯ No

If yes, indicate type of surgery: Date of surgery:

If no surgery has been done, is an aneurysm present that does not meet the requirements for surgical correction? ◯ Yes ◯ No

SECTION VI - AORTIC ANEURYSM: ASCENDING, THORACIC, OR ABDOMINAL

6A. Has the Veteran ever been diagnosed with an aortic aneurysm: ascending, thoracic, or abdominal? ◯ Yes ◯ No

If yes, is it symptomatic? ◯ Yes ◯ No

Has the Veteran had a surgical procedure for an aortic aneurysm: ascending, thoracic, or abdominal? ◯ Yes ◯ No

If yes, indicate type of surgery: Date of surgery:

If no, is an aneurysm present that does not meet the requirements for surgical correction? ◯ Yes ◯ No

6B. Does the Veteran currently have an aortic aneurysm, ascending, thoracic, or abdominal? ◯ Yes ◯ No

If yes, indicate severity:

Five centimeters or larger in diameter ◯ Yes ◯ No

Symptomatic (e.g., precludes exertion) ◯ Yes ◯ No

6C. Does the Veteran have any post-surgical residuals due to treatment for aortic aneurysm, ascending, thoracic, or abdominal? ◯ Yes ◯ No

If yes, describe: _____

If there are non-cardiac symptoms or post-surgical residuals, complete appropriate questionnaire for affected body system.

SECTION VII - ANEURYSM OF A SMALL ARTERY

7A. Has the Veteran been diagnosed with an aneurysm of a small artery? ◯ Yes ◯ No

Is it symptomatic? ◯ Yes ◯ No

If yes, describe symptoms: _____

If yes, has the Veteran had a surgical procedure for an aneurysm of a small artery? ◯ Yes ◯ No

If yes, indicate type of surgery: Date of surgery:

Does the Veteran currently have an aneurysm of a small artery? ◯ Yes ◯ No

Also complete appropriate questionnaire according to body system affected.

7B. Does the Veteran have any post-surgical residuals due to treatment for an aneurysm of a small artery? ◯ Yes ◯ No

If yes, describe: _____

If there are non-cardiac symptoms or post-surgical residuals, complete appropriate questionnaire according to body system affected.

SECTION VIII - RAYNAUD'S DISEASE OR SYNDROME

Note: Trophic changes include, but are not limited to, skin changes (thinning, atrophy, fissuring, ulceration, scarring, absence of hair) as well as nail changes (clubbing, deformities).

For Raynaud's disease, characteristic attacks consist of intermittent and episodic color changes of the digits of one or more extremities, lasting minutes or longer, with occasional pain and paresthesias, and precipitated by exposure to cold or by emotional upsets.

For Raynaud's syndrome, characteristic attacks consist of sequential color changes of the digits of one or more extremities, lasting minutes to hours, sometimes with pain and paresthesias, and precipitated by exposure to cold or by emotional upsets.

8A. Does the Veteran have Raynaud's disease (also known as primary Raynaud's)? ◯ Yes ◯ No

8B. Does the Veteran have Raynaud's syndrome (also known as secondary Raynaud's phenomenon or secondary Raynaud's)? ◯ Yes ◯ No

8C. Is there a history of characteristic attacks? ◯ Yes ◯ No If yes, indicate frequency of characteristic attacks:

◯ Less than once a week ◯ 1 to 3 times a week ◯ 4 to 6 times a week ◯ At least daily

◯ With trophic changes ◯ Without trophic changes

8D. Does the Veteran have two or more digital ulcers? ◯ Yes ◯ No

◯ With trophic changes ◯ Without trophic changes

8E. Does the Veteran have auto-amputation of one or more digits? ◯ Yes ◯ No

SECTION IX - ARTERIOVENOUS (AV) FISTULA, ANGIONEUROTIC EDEMA OR ERYTHROMELALGIA

9A. Does the Veteran have or has ever had a traumatic AV fistula? ◯ Yes ◯ No

If yes, indicate site of traumatic AV fistula:

☐ Right upper extremity ☐ Left upper extremity

☐ Right lower extremity ☐ Left lower extremity ☐ Other location, specify: _____

9B. Indicate findings:

☐ Chronic edema

☐ Right upper extremity ☐ Left upper extremity

☐ Right lower extremity ☐ Left lower extremity

☐ Stasis dermatitis

☐ Right upper extremity ☐ Left upper extremity

☐ Right lower extremity ☐ Left lower extremity

☐ Ulceration

☐ Right upper extremity ☐ Left upper extremity

☐ Right lower extremity ☐ Left lower extremity

☐ Cellulitis

☐ Right upper extremity ☐ Left upper extremity

☐ Right lower extremity ☐ Left lower extremity

9C. Cardiovascular symptoms:

☐ No cardiac involvement

☐ Enlarged heart

☐ Wide pulse pressure

☐ Tachycardia

☐ High-output heart failure

If related to traumatic AV fistula, complete Heart Conditions questionnaire.

9D. Is there more than one traumatic AV fistula? ◯ Yes ◯ No

If yes, provide location and findings for each traumatic AV fistula using the above format:

9E. Does the Veteran have chronic angioneurotic edema? ◯ Yes ◯ No

If yes, indicate severity, duration, and frequency of attacks. Check all that apply:

☐ With laryngeal involvement (of any duration)

Duration:

◯ Occurs 1 or 2 times a year

◯ Occurs more than 2 times a year

☐ Without laryngeal involvement

Duration:

◯ Lasts 1 to 7 days

◯ Lasts longer than 7 days

Frequency:

◯ Occurs less than 2 times a year

◯ Occurs 2 to 4 times a year

◯ Occurs 5 to 8 times a year

◯ Occurs more than 8 times a year

Note: For purposes of this section, a characteristic attack of erythromelalgia consists of burning pain in the hands, feet, or both, usually bilateral and symmetrical, with increased skin temperature and redness, occurring at warm ambient temperatures.

9F. Does the Veteran have or has ever had an erythromelalgia? ◯ Yes ◯ No

If yes, indicate severity, duration and frequency of characteristic attacks. Check all that apply:

◯ Does not restrict most routine daily activities

◯ Restricts most routine daily activities

◯ Occurs less than 3 times a week

◯ Occurs at least 3 times a week

◯ Occurs daily

◯ Occurs more than once a day

☐ Lasts an average of more than 2 hours each

◯ Responds to treatment

◯ Responds poorly to treatment

SECTION X - TUMORS AND NEOPLASMS

10A. Does the Veteran currently have, or has had, a benign or malignant neoplasm or metastases related to any condition in the diagnosis section?

◯ Yes ◯ No If yes, complete the following section.

10B.The neoplasm is:

◯ Benign

◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

◯ Primary ◯ Secondary (metastatic) (if secondary, indicate the primary site, if known): _____

10C. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?

◯ Yes ◯ No; watchful waiting

If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

☐ Treatment completed

☐ 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: _____

☐ Antineoplastic chemotherapy

Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

☐ Other therapeutic procedure

If checked, describe procedure: _____

Date of most recent procedure: _____

☐ Other therapeutic treatment

If checked, describe treatment: _____

Date of completion of treatment or anticipated date of completion: _____

10D. Does the Veteran currently have any residuals 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 residuals or complications (brief summary), and also complete the appropriate questionnaire:

10E. 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 XI - AMPUTATION AND ASSISTIVE DEVICES

11A. Has the Veteran had an amputation of an extremity due to a vascular condition? ◯ Yes ◯ No

If yes, complete the Amputations Questionnaire.

11B. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible?

◯ Yes ◯ No If yes, identify 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, specify _____	Frequency of use:	◯ Occasional	◯ Regular	◯ Constant

11C. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the device used for each condition:

11D. Due to a vascular condition, is there functional impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis? Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance, propulsion, etc.

◯ Yes, functioning is so diminished that amputation with prosthesis would equally well serve the Veteran

◯ No

If yes, indicate extremity(ies). Check all extremities for which this applies:

☐ Right upper

☐ Right lower

☐ Left upper

☐ Left lower

11E. For each checked extremity, describe loss of affected function, identify the condition causing loss of function and provide specific examples. Brief summary:

SECTION XII - 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:

12B. 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 the appropriate dermatological questionnaire.

12C. Comments, if any:

SECTION XIII - DIAGNOSTIC TESTING

Note: In cases where ABI testing does not clinically reflect the severity of the Veteran's peripheral arterial disease, and the examiner states that AP, TP, and/or $TcPO_2$ testing is needed and not of record, the clinically appropriate testing (AP, TP, and/or $TcPO_2$) is required.

13A. Has ankle/brachial index (ABI) testing been performed? ◯ Yes ◯ No

If unable to perform provide reason: _____

If yes, provide most recent results:

☐ Right ankle/brachial index: Date:

☐ Left ankle/brachial index: Date:

13B. If only ABI testing is available, does ABI sufficiently reflect the severity of the Veteran's peripheral arterial disease? ◯ Yes ◯ No ◯ N/A

13C. Provide the results and dates of testing for the following, if available:

Right ankle pressure (AP): _____ Date _____

Left ankle pressure (AP): _____ Date _____

Right toe pressure (AP): _____ Date _____

Left toe pressure (TP): _____ Date _____

Right foot transcutaneous oxygen tension ($TcPO_2$): _____ Date _____

Left foot transcutaneous oxygen tension ($TcPO_2$): _____ Date _____

13D. Are there any other significant diagnostic test findings that were reviewed in conjunction with this examination that are related to the claimed condition(s) and/or diagnosis(es)? ◯ Yes ◯ No

If yes, provide type of test or procedure, date, and results (brief summary):

SECTION XIV - 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.

14A. 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 XV - REMARKS

15A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

SECTION XVI - EXAMINER'S CERTIFICATION AND SIGNATURE

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

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

16A. Examiner's signature:	16B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

16C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	16D. Date Signed:

16E. Examiner's phone/fax numbers:	16F. National Provider Identifier (NPI) number:	16G. Medical license number and state:

16H. Examiner's address: