Department of Veterans Affairs

BREAST CONDITIONS AND DISORDERS 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.

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 disorder of the breast(s)?

◯ Yes ◯ No

1C. 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 -

1D. 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:

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

4A. 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, SYMPTOMS, AND SCARS

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.

6A. 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

7A. 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

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.

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.

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:	