Department of Veterans Affairs

# ENDOCRINE DISEASES
# (Other than Thyroid, Parathyroid or Diabetes Mellitus)
# 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

1A. DOES THE VETERAN HAVE OR HAS HE OR SHE EVER HAD AN ENDOCRINE CONDITION? (This is the condition the veteran is claiming or for which an exam has been requested)

◯ YES ◯ NO (If "Yes," complete Item 1B)

1B. SELECT THE VETERAN'S CONDITION (Check all that apply):

| | | | | |
|---|---|---|---|---|
| ☐ CUSHING'S SYNDROME | ICD code: | | Date of diagnosis | |
| ☐ ACROMEGALY | ICD code: | | Date of diagnosis | |
| ☐ DIABETES INSIPIDUS | ICD code: | | Date of diagnosis | |
| ☐ ADDISON'S DISEASE (adrenocortical insufficiency) | ICD code: | | Date of diagnosis | |

☐ POLYGLANDULAR SYNDROME (multiple endocrine neoplasia, auto-immune polyglandular syndrome) ICD code: _____ Date of diagnosis _____

☐ HYPOPITUITARISM ICD code: _____ Date of diagnosis _____

☐ HYPERPITUITARISM (prolactin secreting pituitary dysfunction) ICD code: _____ Date of diagnosis _____

◯ BENIGN ◯ MALIGNANT

◯ ACTIVE ◯ IN REMISSION

☐ HYPERALDOSTERONISM ICD code: _____ Date of diagnosis _____

◯ BENIGN ◯ MALIGNANT

◯ ACTIVE ◯ IN REMISSION

☐ PHEOCHROMOCYTOMA ICD code: _____ Date of diagnosis _____

◯ BENIGN ◯ MALIGNANT

◯ ACTIVE ◯ IN REMISSION

☐ HYPOGONADISM ICD code: _____ Date of diagnosis _____

☐ NEOPLASM, BENIGN, ANY SPECIFIED PART OF THE ENDOCRINE SYSTEM ICD code: _____ Date of diagnosis _____

☐ NEOPLASM, MALIGNANT, ANY SPECIFIED PART OF THE ENDOCRINE SYSTEM ICD code: _____ Date of diagnosis _____

☐ ACTIVE MALIGNANCY

☐ UNDERGOING SURGICAL, X-RAY, ANTINEOPLASTIC CHEMOTHERAPY OR OTHER THERAPEUTIC PROCEDURE

☐ IN REMISSION

☐ 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 ENDOCRINE CONDITION(S), LIST USING ABOVE FORMAT:

1D. PLEASE SELECT THE BODY SYSTEMS AFFECTED BY THE DIAGNOSES LISTED IN SECTION 1B.

☐ MUSCULOSKELETAL SYMPTOMS, (complete appropriate musculoskeletal DBQ)

☐ RESPIRATORY SYMPTOMS, (complete appropriate respiratory DBQ)

☐ CARDIOVASCULAR SYMPTOMS, (complete appropriate cardiovascular DBQ)

☐ GASTROINTESTINAL SYMPTOMS, (complete appropriate gastrointestinal DBQ)

☐ GENITOURINARY SYMPTOMS, (complete appropriate genitourinary DBQ)

☐ REPRODUCTIVE SYMPTOMS, (complete appropriate gynecological or male reproductive organ DBQ)

☐ SKIN SYMPTOMS, (complete appropriate dermatological DBQ)

☐ EYE INVOLVEMENT, (complete appropriate ophthalmological DBQ)

☐ NEUROLOGICAL SYMPTOMS, (complete appropriate neurological DBQ)

☐ MENTAL AND PSYCHOLOGICAL SYMPTOMS, (complete appropriate psychological DBQ)

☐ DENTAL AND ORAL CONDITIONS, (complete appropriate dental and oral DBQ)

## SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S ENDOCRINE CONDITION (brief summary):

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF AN ENDOCRINE CONDITION?

◯ YES ◯ NO

(If "Yes," specify the condition and list only those medications required for the Veteran's endocrine condition):

2C. HAS THE VETERAN HAD SURGERY FOR AN ENDOCRINE CONDITION?

◯ YES ◯ NO

(If "Yes," specify the condition and type of surgery): _____ (Date of surgery): _____

2D. HAS THE VETERAN HAD ANY OTHER TYPE OF TREATMENT FOR AN ENDOCRINE CONDITION?

◯ YES ◯ NO

(If "Yes," specify the condition and type of treatment): _____ (Date of treatment): _____

## SECTION III - CUSHING'S SYNDROME

3A. CUSHING'S SYNDROME

(Date of initial diagnosis:) _____

Has it been more than 6 months since the initial diagnosis?

◯ YES ◯ NO

If yes, evaluate residuals with the appropriate DBQ (refer to and select appropriate checkbox from section 1D).

If no, please select the symptoms below:

☐ As active, progressive disease

☐ Areas of osteoporosis

☐ Hypertension

☐ Proximal upper extremity muscle wasting that results in inability to climb stairs

☐ Proximal upper extremity muscle wasting that results in inability to rise from a deep chair without assistance

☐ Proximal upper extremity muscle wasting that results in inability to rise from squatting position

☐ Proximal upper extremity muscle wasting that results in inability to raise arms

☐ Proximal lower extremity muscle wasting that results in inability to climb stairs

☐ Proximal lower extremity muscle wasting that results in inability to rise from a deep chair without assistance

☐ Proximal lower extremity muscle wasting that results in inability to rise from squatting position

☐ Proximal lower extremity muscle wasting that results in inability to raise arms

☐ Striae

☐ Obesity

☐ Moon face

☐ Glucose intolerance

☐ Vascular fragility

☐ Other, please specify: _____

## SECTION IV - ACROMEGALY

4A. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO ACROMEGALY?

◯ YES ◯ NO

(If "Yes," check all that apply)

☐ ENLARGEMENT OF ACRAL PARTS

☐ OVERGROWTH OF LONG BONES

☐ GLUCOSE INTOLERANCE

☐ ARTHROPATHY

☐ HYPERTENSION (If checked, provide BPx3): _____

☐ EVIDENCE OF INCREASED INTRACRANIAL PRESSURE (such as visual field defect)

☐ CARDIOMEGALY

☐ OTHER (Specify): _____

4B. DOES THE VETERAN CURRENTLY HAVE ANY ADDITIONAL FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO ACROMEGALY?

◯ YES ◯ NO

If yes, evaluate residuals with the appropriate DBQ pertaining to the affected body system.

## SECTION V - DIABETES INSIPIDUS

5A. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO DIABETES INSIPIDUS?

◯ YES ◯ NO

(If "Yes," check all that apply)

☐ PERSISTENT POLYURIA

☐ REQUIRES CONTINUOUS HORMONAL THERAPY

5B. DOES THE VETERAN CURRENTLY HAVE ANY ADDITIONAL FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO DIABETES INSIPIDUS?

◯ YES ◯ NO

If yes, evaluate residuals with the appropriate DBQ pertaining to the affected body system.

5C. OTHER, DESCRIBE:

## SECTION VI - ADDISON'S DISEASE (ADRENOCORTICAL INSUFFICIENCY)

6A. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO ADDISON'S DISEASE?

◯ YES ◯ NO

(If "Yes," check all that apply)

☐ CORTICOSTEROID THERAPY REQUIRED FOR CONTROL

☐ WEAKNESS AND FATIGABILITY

☐ ADDISONIAN CRISIS (acute adrenal insufficiency)

(If checked, indicate frequency of Addisonian crises in past 12 months)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6

☐ ADDISONIAN "EPISODES"

(If checked, indicate frequency of Addisonian "episodes" in past 12 months)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ More than 5

☐ OTHER (Specify): _____

6B. FOR ALL CHECKED CONDITIONS, DESCRIBE:

NOTE: An Addisonian crisis consists of the rapid onset of peripheral vascular collapse (with acute hypotension and shock), with findings that may include anorexia; nausea; vomiting; dehydration; profound weakness; pain in the abdomen; legs and back; fever; apathy and depressed mentation with possible progression to coma, renal shutdown and death.
For VA purposes, an Addisonian "episode" is a less acute and less severe event than an Addisonian crisis and may consist of anorexia, nausea, vomiting, diarrhea, dehydration, weakness, malaise, orthostatic hypotension or hypoglycemia, but not peripheral vascular collapse.

## SECTION VII - OTHER ENDOCRINE CONDITIONS

7A. DOES THE VETERAN HAVE ANY OTHER ENDOCRINE CONDITIONS?

◯ YES ◯ NO

7B. IF YES, SPECIFY CONDITION AND DESCRIBE ANY CURRENT FINDINGS, SIGNS AND SYMPTOMS:

## SECTION VIII - TUMORS AND NEOPLASMS

8A. 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.

8B. Is the neoplasm:

◯ Benign

◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

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

8C. 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: _____

8D. 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:

8E. 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 IX - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, AND SYMPTOMS

9A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

◯ YES ◯ NO

(If "Yes," describe - brief summary)

9B. 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 appropriate dermatological DBQ)

9C. COMMENTS, IF ANY:

## SECTION X - DIAGNOSTIC TESTING

NOTE: If diagnostic test results are in the medical record and reflect the veteran's current endocrine condition, repeat testing is not required.

10A. HAVE IMAGING STUDIES BEEN PERFORMED?

◯ YES ◯ NO

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

☐ Magnetic resonance imaging (MRI) Date: _____ Results: _____

☐ Computed tomography (CT) Date: _____ Results: _____

☐ Other: _____ Date: _____ Results _____

10B. HAS LABORATORY TESTING BEEN PERFORMED?

◯ YES ◯ NO (If "Yes," indicate type of test, date and results)

Type of test: _____ Date: _____ Results: _____

Type of test: _____ Date: _____ Results: _____

Type of test: _____ Date: _____ Results: _____

10C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

◯ YES ◯ NO

If "Yes," indicate type of test or procedure, date and results (brief summary):

## SECTION XI - FUNCTIONAL IMPACT

11A. DOES THE VETERAN'S ENDOCRINE CONDITION IMPACT HIS OR HER ABILITY TO WORK?

◯ Yes ◯ NO

(If "Yes," describe the impact of each of the Veteran's endocrine conditions providing one or more examples)

## SECTION XII - REMARKS

12. REMARKS, if any:

## SECTION XIII - 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.

| 13A. Examiner's signature: | 13B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C): |
|---|---|
| 13C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice): | 13D. Date Signed: |

| 13E. Examiner's phone/fax numbers: | 13F. National Provider Identifier (NPI) number: | 13G. Medical license number and state: |
|---|---|---|

13H. Examiner's address: