



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:

Form with checkboxes for 'Veteran/Claimant', 'Third party (please list name(s) of organization(s) or individual(s))', and 'Other: please describe' with corresponding text boxes.

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? [Text box]

EVIDENCE REVIEW

Evidence reviewed:

Form with radio buttons for 'No records were reviewed' and 'Records reviewed'

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

[Large empty text box for evidence review details]

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)

Form with radio buttons for YES and NO, and instruction: (If "Yes," complete Item 1B)

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

Form with checkboxes for CUSHING'S SYNDROME, ACROMEGALY, DIABETES INSIPIDUS, and ADDISON'S DISEASE, with ICD code and Date of diagnosis fields.

<input type="checkbox"/> POLYGLANDULAR SYNDROME (multiple endocrine neoplasia, auto-immune polyglandular syndrome)	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> HYPOPITUITARISM	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> HYPERPITUITARISM (prolactin secreting pituitary dysfunction)	ICD code: _____	Date of diagnosis: _____
<input type="radio"/> BENIGN <input type="radio"/> MALIGNANT <input type="radio"/> ACTIVE <input type="radio"/> IN REMISSION		
<input type="checkbox"/> HYPERALDOSTERONISM	ICD code: _____	Date of diagnosis: _____
<input type="radio"/> BENIGN <input type="radio"/> MALIGNANT <input type="radio"/> ACTIVE <input type="radio"/> IN REMISSION		
<input type="checkbox"/> PHEOCHROMOCYTOMA	ICD code: _____	Date of diagnosis: _____
<input type="radio"/> BENIGN <input type="radio"/> MALIGNANT <input type="radio"/> ACTIVE <input type="radio"/> IN REMISSION		
<input type="checkbox"/> HYPOGONADISM	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> NEOPLASM, BENIGN, ANY SPECIFIED PART OF THE ENDOCRINE SYSTEM	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> NEOPLASM, MALIGNANT, ANY SPECIFIED PART OF THE ENDOCRINE SYSTEM	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> ACTIVE MALIGNANCY <input type="checkbox"/> UNDERGOING SURGICAL, X-RAY, ANTINEOPLASTIC CHEMOTHERAPY OR OTHER THERAPEUTIC PROCEDURE <input type="checkbox"/> IN REMISSION		
<input type="checkbox"/> 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):

<input type="checkbox"/> Magnetic resonance imaging (MRI)	Date: _____	Results: _____
<input type="checkbox"/> Computed tomography (CT)	Date: _____	Results: _____
<input type="checkbox"/> 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:

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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. Examiners signature: _____	13B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C): _____
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13C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice): _____	13D. Date Signed: _____
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13E. Examiner's phone/fax numbers: _____	13F. National Provider Identifier (NPI) number: _____	13G. Medical license number and state: _____
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13H. Examiner's address: _____ _____
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