Department of Veterans Affairs

HIV-RELATED ILLNESSES 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 currently have an HIV-related illness?

◯ Yes ◯ No ICD code: Date of diagnosis:

Other (specify):

Other diagnosis #1 ICD code: Date of diagnosis:

Other diagnosis #2 ICD code: Date of diagnosis:

Other diagnosis #3 ICD code: Date of diagnosis:

1B. If there are additional diagnoses that pertain to an HIV-related illness, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's HIV-related illness(es):

2B. Is continuous medication required for control of HIV-related illness(es)?

◯ Yes ◯ No

If "Yes," list only those medications required for the Veteran's HIV-related illness(es)) (If the Veteran has more than one HIV-related illness(es), specify the condition for which each medication is required:

2C. Does the Veteran have any complications due to current or previous medications taken for HIV-related illness(es)?

◯ Yes ◯ No

If "Yes," list medication and describe complication(s) due to medication(s):

SECTION III - SIGNS, SYMPTOMS AND FINDINGS

3A. Does the Veteran have any signs, symptoms or findings attributable to an HIV-related illness?

◯ Yes ◯ No If "Yes," check all that apply:

☐ Constitutional symptoms (fever, weight loss, fatigue, malaise, decreased appetite, etc.) attributable to an HIV-related illness

If checked, indicate frequency and severity:

☐ Refractory ☐ Recurrent

Describe constitutional symptoms: _____

☐ Diarrhea attributable to an HIV-related illness

If checked, indicate frequency and severity:

◯ Intermittent ◯ > Intermittent

Describe: _____

☐ Weight loss attributable to an HIV-related illness

☐ Progressive weight loss ☐ Pathological weight loss

Provide baseline weight: _____ and current weight: _____

Note: For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease

☐ Other (Describe):

SECTION IV - SECONDARY DISEASES

4A. Does the Veteran have any secondary diseases attributable to an HIV-related illness?

◯ Yes ◯ No

If "Yes," check all that apply:

☐ Musculoskeletal system (complete appropriate musculoskeletal questionnaire)

☐ Organs of special sense (complete appropriate audio/ENT questionnaire)

☐ Respiratory system (complete appropriate respiratory/ENT questionnaire)

☐ Cardiovascular system (complete appropriate cardiovascular questionnaire)

☐ Digestive system (complete appropriate gastrointestinal questionnaire)

☐ Genitourinary system (complete appropriate genitourinary questionnaire)

☐ Endocrine system (complete appropriate endocrine questionnaire)

☐ Hematologic and lymphatic system (complete appropriate hematologic questionnaire)

☐ Reproductive system (complete appropriate gynecological or male reproductive organ questionnaire)

☐ Dermatological system (complete appropriate dermatological questionnaire)

☐ Ophthalmological system (complete appropriate ophthalmological questionnaire)

☐ Neurological system (complete appropriate neurological questionnaire)

☐ Mental/psychological conditions (complete appropriate psychological questionnaire)

☐ Dental and oral conditions system (complete appropriate dental and oral questionnaire)

SECTION V - INFECTIOUS AND ONCOLOGIC COMPLICATIONS

5A. Does the Veteran now have any HIV-related opportunistic infectious or oncologic conditions?

◯ Yes ◯ No

If "Yes," check all that apply:

- ☐ Candidiasis of the bronchi, trachea, esophagus, or lungs
- ☐ Invasive cervical cancer
- ☐ Coccidioidomycosis
- ☐ Cryptococcosis
- ☐ Cryptosporidiosis
- ☐ Cytomegalovirus (particularly CMV retinitis)
- ☐ HIV-related encephalopathy
- ☐ Herpes simplex-chronic ulcers for greater than one month, or bronchitis, pneumonia, or esophagitis
- ☐ Histoplasmosis
- ☐ Isosporiasis (chronic intestinal)
- ☐ Kaposi's sarcoma
- ☐ Lymphoma
- ☐ Mycobacterium avium complex
- ☐ Tuberculosis
- ☐ Pneumocystis jirovecii (carinii) pneumonia
- ☐ Pneumonia, recurrent
- ☐ Progressive multifocal leukoencephalopathy
- ☐ Salmonella septicemia, recurrent
- ☐ Toxoplasmosis of the brain
- ☐ Wasting syndrome due to HIV

5B. For each checked condition, (except those for which an additional questionnaire is completed), describe (providing date of onset, and brief summary of symptoms, treatment and course):

5C. Does the Veteran have recurrent opportunistic infection(s)?

◯ Yes ◯ No

If "Yes," describe (providing type of infection(s), date(s) of first onset, brief summary of symptoms, treatment and course): Also complete the appropriate questionnaire(s), if applicable.

SECTION VI - SUMMARY

6A. Based on symptoms and findings from this exam, complete the following section to provide a summary of the severity of the Veteran's HIV-related condition (this summary provides useful information for VA purposes) check all that apply:

☐ Asymptomatic, with or without lymphadenopathy or decreased T4 cell count

☐ Symptomatic, development of HIV-related constitutional symptoms

☐ Current T4 cell count between 200 and 500

☐ Use of approved medication(s)

☐ Evidence of depression with employment limitations

☐ Evidence of memory loss with employment limitations

☐ Recurrent constitutional symptoms, intermittent diarrhea, and on approved medication(s)

☐ Current T4 cell count less than 200

☐ Refractory constitutional symptoms, diarrhea and pathological weight loss

☐ Development of AIDS-related opportunistic infection or neoplasm

☐ AIDS with recurrent opportunistic infections

☐ AIDS with secondary diseases afflicting multiple body systems

☐ HIV-related illness with debility and progressive weight loss

Note: For VA purposes, approved medications include medications prescribed as part of a research protocol at an accredited medical institution.

SECTION VII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

7A. 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):

7B. 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.

7C. Comments, if any:

SECTION VIII - DIAGNOSTIC TESTING

Note - If testing has been performed and reflects the Veteran's current condition, repeat testing is not required.

8A. Has clinically relevant laboratory testing been performed or reviewed in conjunction with this examination?

◯ Yes ◯ No

If "Yes," check all that apply:

☐ CD4 (T4 cell) lymphocyte count: _____ Date: _____

☐ Lowest (nadir) CD4 (T4 cell) lymphocyte count, if available: _____ Date if known: _____

8B. Have clinically relevant diagnostic imaging studies or other diagnostic procedures been performed or reviewed in conjunction with this examination and are the results available?

◯ Yes ◯ No

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

8C. Are there any other clinically relevant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

◯ Yes ◯ No

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

SECTION IX - FUNCTIONAL IMPACT

9A. Do any of the Veteran's HIV-related illnesses or complications impact his or her ability to work?

◯ Yes ◯ No

If "Yes," describe impact of each of the Veteran's HIV-related illness(es), providing one or more examples:

SECTION X - REMARKS

10A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

SECTION XI - 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.

11A. Examiner's signature:	11B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):
11C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	11D. Date Signed:
11E. Examiner's phone/fax numbers:	11F. National Provider Identifier (NPI) number:	11G. Medical license number and state:
11H. Examiner's address:	