Department of Veterans Affairs

RESPIRATORY CONDITIONS (OTHER THAN TUBERCULOSIS AND SLEEP APNEA) 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. Select diagnoses associated with the claimed condition(s) (check all that apply):

☐ The Veteran does not have a current diagnosis associated with any claimed condition(s) listed above. (Explain your findings and reasons in the Remarks section)

☐ Asthma ICD code: _____ Date of diagnosis: _____

☐ Emphysema ICD code: _____ Date of diagnosis: _____

☐ Chronic obstructive pulmonary disease (COPD) ICD code: _____ Date of diagnosis: _____

☐ Chronic bronchitis ICD code: _____ Date of diagnosis: _____

☐ Constrictive bronchiolitis ICD code: _____ Date of diagnosis: _____

☐ Interstitial lung disease (if checked, specify):

_____ ICD code: _____ Date of diagnosis: _____

NOTE - Interstitial lung diseases include but are not limited to asbestosis, diffuse interstitial fibrosis, interstitial pneumonitis, fibrosing alveolitis, desquamative interstitial pneumonitis, pulmonary alveolar proteinosis, eosinophilic granuloma of lung, drug-induced pulmonary pneumonitis and fibrosis, radiation-induced pulmonary pneumonitis and fibrosis, hypersensitivity pneumonitis (extrinsic allergic alveolitis) and pneumoconiosis such as silicosis, anthracosis, etc.

☐ Restrictive lung disease (If checked, specify):

_____ ICD code: _____ Date of diagnosis: _____

NOTE - Restrictive lung diseases include but are not limited to diaphragm paralysis or paresis, spinal cord injury with respiratory insufficiency, kyphoscoliosis, pectus excavatum, pectus carinatum, traumatic chest wall defect, pneumothorax, hernia, etc., post-surgical residual (lobectomy, pneumonectomy, etc.), chronic pleural effusion or fibrosis.

☐ Mycotic lung disease (If checked, specify):

_____ ICD code: _____ Date of diagnosis: _____

NOTE - Mycotic lung diseases include but are not limited to histoplasmosis, blastomycosis, cryptococosis, aspergillosis, or mucomycosis.

☐ Sarcoidosis ICD code: _____ Date of diagnosis: _____

☐ Benign or malignant neoplasm or metastases of respiratory system (If checked, specify):

_____ ICD code: _____ Date of diagnosis: _____

☐ Pulmonary vascular disease (Including pulmonary thromboembolism)(If checked, specify):

_____ ICD code: _____ Date of diagnosis: _____

☐ Pleurisy with empyema, with or without pleurocutaneous fistula

◯ Unresolved ◯ Resolved ICD code: _____ Date of diagnosis: _____

☐ Other diagnosis (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: _____

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

Note - If diagnosed with Sleep apnea and/or Narcolepsy complete the Sleep Apnea and/or Narcolepsy Questionnaire(s), in lieu of this one.

SECTION II - MEDICAL HISTORY

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

2B. Does the Veteran's respiratory condition require the use of oral or parenteral corticosteroid medications?

◯ Yes ◯ No (If "Yes," complete the following):

☐ Requires chronic low dose (maintenance) corticosteroids

☐ Requires intermittent courses or bursts of systemic (oral or parenteral) corticosteriods

(If checked, indicate number of courses or bursts in past 12 months):

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 or more

☐ Requires systemic (oral or parenteral) high dose (therapeutic) corticosteroids for control

☐ Requires daily use of systemic (oral or parenteral) high dose corticosteroids

☐ Requires daily use of systemic (oral or parenteral) immuno-suppressive medications

☐ Other, describe: _____

(If the Veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the need for corticosteroids or immunosuppressive medications):

_____

2C. Does the Veteran's respiratory condition require the use of inhaled medications?

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

☐ Inhalational bronchodilator therapy

(If checked, indicate frequency): ◯ Intermittent ◯ Daily

☐ Inhalational anti-inflammatory medication

(If checked, indicate frequency): ◯ Intermittent ◯ Daily

☐ Other inhaled medications, describe: _____

If the Veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the need for inhaled medications:

_____

2D. Does the Veteran's respiratory condition require the use of oral bronchodilators?

◯ Yes ◯ No

(If "Yes," indicate frequency): ◯ Intermittent ◯ Daily

2E. Does the Veteran's respiratory condition require the use of antibiotics?

◯ Yes ◯ No

(If "Yes," list antibiotics, dose, frequency and condition for which antibiotics are prescribed):

_____

2F. Does the Veteran require outpatient oxygen therapy for his or her respiratory condition?

◯ Yes ◯ No

(If "Yes," does the Veteran require continuous oxygen therapy (>17 hours/day)?): ◯ Yes ◯ No

(If the Veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the requirement for oxygen therapy):

SECTION III - PULMONARY CONDITIONS

3A. Does the Veteran have any of the following pulmonary conditions?

◯ Yes ◯ No (If "No," proceed to Section IV) (If "Yes," check all that apply):

- ☐ Asthma (If checked, complete Part A below)
- ☐ Bronchiectasis (If checked, complete Part B below)
- ☐ Sarcoidosis (If checked, complete Part C below)
- ☐ Pulmonary embolism and related diseases (If checked, complete Part D below)
- ☐ Bacterial lung infection (If checked, complete Part E below)
- ☐ Mycotic lung infection (If checked, complete Part F below)
- ☐ Pneumothorax (If checked, complete Part G below)
- ☐ Gunshot/fragment wound (If checked, complete Part H below)
- ☐ Cardiopulmonary complications (If checked, complete Part I below)
- ☐ Respiratory failure (If checked, complete Part J below)
- ☐ Tumors or neoplasms (If checked, complete Part K below)
- ☐ Other pulmonary conditions, pertinent physical findings or scars due to pulmonary conditions: (If checked, complete Part L below)

PART A - ASTHMA

1A. Has the Veteran had any asthma attacks with episodes of respiratory failure in the past 12 months?

◯ Yes ◯ No (If "Yes," indicate average number of asthma attacks with episodes of respiratory failure per week in past 12 months):

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 or more

1B. Has the Veteran had any physician visits for required care of exacerbations?

◯ Yes ◯ No

(If "yes," describe frequency and severity of exacerbations):

(Indicate frequency of physician visits for required care of exacerbations over past 12 months):

◯ Less frequently than monthly ◯ At least monthly

PART B - BRONCHIECTASIS

2A. Indicate any findings, signs and symptoms that are attributable to bronchiectasis

☐ Productive cough (If checked, indicate frequency and severity of productive cough (check all that apply)):

- ☐ Intermittent
- ☐ Daily
- ☐ Near constant
- ☐ Purulent sputum at times
- ☐ Blood-tinged sputum at times

☐ Other, describe: _____

☐ Acute infection

(If checked, indicate number of infections requiring a prolonged course of antibiotics (lasting 4 to 6 weeks) in the past 12 months):

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 or more

☐ Requiring a course of antibiotics at least twice a year

☐ Requiring a prolonged course of antibiotics (lasting 4 to 6 weeks) more than twice a year

☐ Requiring antibiotic usage almost continuously

☐ Anorexia (If checked, describe): _____

☐ Weight loss (If checked, provide baseline weight: _____ and current weight: _____)

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

☐ Frank hemoptysis (If checked, describe): _____

☐ Other, describe: _____

2B. Has the Veteran had any incapacitating episodes of infection due to bronchiectasis?

(NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician)

◯ Yes ◯ No (If "Yes," indicate total duration of incapacitating episodes of infection in past 12 months):

◯ 0 to no more than 2 weeks

◯ 2 to no more than 4 weeks

◯ 4 to no more than 6 weeks

◯ At least 6 weeks or more

PART C - SARCOIDOSIS

3A. Does the Veteran have any findings, signs or symptoms attributable to sarcoidosis?

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

☐ No physiologic impairment ☐ No symptoms

☐ Persistent symptoms (If checked, describe): _____

☐ Chronic hilar adenopathy

☐ Stable lung infiltrates

☐ Pulmonary involvement

☐ Progressive pulmonary disease (If checked, describe): _____

☐ Cardiac involvement with congestive heart failure

☐ Fever (If checked, describe): _____

☐ Night sweats (If checked, describe): _____

☐ Weight loss (If checked, provide baseline weight: _____ and current weight: _____)

(NOTE: For VA purposes, baseline weight is the average weight for a 2-year period preceding onset of disease)

☐ Other, describe: _____

3B. Indicate stage disgnosed by x-ray findings

◯ Stage 1: Bihilar lymphadenopathy

◯ Stage 2: Bihilar lymphadenopathy and reticulonodular infiltrates

◯ Stage 3: Bilateral pulmonary infiltrates

◯ Stage 4: Fibrocystic sarcoidosis typically with upward hilar retraction, cystic and bullous changes

3C. Does the Veteran have opthalmologic, renal, cardiac, neurologic, or other organ system involvement due to sarcoidosis?

◯ Yes ◯ No (If "Yes," also complete appropriate additional Questionnaires)

PART D - PULMONARY EMBOLISM AND RELATED DISEASES

4A. Select the statement(s) that best describe the Veteran's pulmonary vascular disease or pulmonary embolism condition (Check all that apply):

☐ Asymptomatic, following resolution of pulmonary thromboembolism

☐ Symptomatic, following resolution of acute pulmonary embolism

☐ Chronic pulmonary thromboembolism requiring anticoagulant therapy

☐ Following inferior vena cava surgery

☐ Chronic pulmonary thromboembolism

☐ Pulmonary hypertension secondary to other obstructive disease of pulmonary arteries or veins

☐ Other, describe: _____

PART E - BACTERIAL LUNG INFECTION

5A. Identify type of bacterial lung infection:

☐ Actinomycosis ☐ Nocardiosis ☐ Chronic lung abscess ☐ Other, describe: _____

5B. Indicate current status of the Veteran's bacterial infection of the lung

◯ Active ◯ Inactive

5C. Does the Veteran have any findings, signs and symptoms attributable to a bacterial infection of the lung or chronic lung abscess?

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

☐ Fever

☐ Night sweats

☐ Weight loss (If checked, provide baseline weight: _____ and current weight: _____)

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

☐ Hemoptysis

☐ Other, describe: _____

PART F - MYCOTIC LUNG DISEASES

6A. Indicate status of mycotic lung disease (including histoplasmosis of lung, coccidioidomycosis, blastomycosis, cryptococcosis, aspergillosis, or mucormycosis) (Check all that apply):

☐ No symptoms

☐ Chronic pulmonary mycosis

☐ Healed and inactive mycotic lesions

☐ Occasional productive cough

☐ Occasional minor hemoptysis

☐ Requires suppressive therapy

☐ Fever

☐ Night sweats

☐ Weight loss (If checked, provide baseline weight: _____ and current weight: _____)

(NOTE: For VA purposes, baseline weight is the average weight for a 2-year period preceding onset of disease)

☐ Massive hemoptysis

☐ Other, describe: _____

PART G - PNEUMOTHORAX

7A. Indicate the type of pneumothorax, treatment and residual conditions, if any (Check all that apply):

- ☐ Spontaneous total pneumothorax
- ☐ Spontaneous partial pneumothorax
- ☐ Traumatic total pneumothorax
- ☐ Traumatic partial pneumothorax
- ☐ Resulting in hospitalization (If checked, provide date of hospital admission _____ Resulting in hospitalization date of discharge _____)
- ☐ Resulting in residual conditions Resulting in residual conditions (If checked, describe): _____
- ☐ Other, describe: _____

PART H - GUNSHOT/FRAGMENT WOUND

8A. Select the statement(s) that best describe the Veteran's gunshot or fragment wound or the pleural cavity and residuals, if any (Check all that apply):

- ☐ Bullet or missile retained in lung
- ☐ Pain or discomfort on exertion
- ☐ Scattered rales
- ☐ Some limitation of excursion of diaphragm or of lower chest expansion
- ☐ Other, describe: _____

NOTE: If any muscles (other than those which control respiration) are affected by this injury, also complete a Muscle Injuries Questionnaire

PART I - CARDIOPULMONARY COMPLICATIONS

9A. Does the Veteran's respiratory condition result in cardiopulmonary complications such as cor pulmonale, right ventricular hypertrophy or pulmonary hypertension?

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

- ☐ Cor pulmonale (right heart failure)
- ☐ Right ventricular hypertrophy
- ☐ Pulmonary hypertension (shown by echocardiogram or cardiac catheterization; report test results in Diagnostic Testing Section)
- ☐ Other, describe: _____

9B. If the Veteran has more than one respiratory condition, indicate which condition is predominantly responsible for the cardiopulmonary complications:

PART J - RESPIRATORY FAILURE

10A. Provide dates and describe the Veteran's episodes of acute respiratory failure:

10B. If the Veteran has more than one respiratory condition, indicate which condition is predominantly responsible for the episodes of respiratory failure:

PART K - TUMORS AND NEOPLASMS

11A. Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the diagnosis section?

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

11B. Is the neoplasm:

◯ Benign

◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

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

11C. 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: _____

11D. 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:

11E. 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:

PART L - 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 (brief summary):

12B. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the diagnosis section above?

◯ Yes ◯ No

If yes, are any of these scars painful or unstable, have a total area equal to or greater than 39 square cm (6 square inches); or are located on the head, face or neck? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

◯ Yes ◯ No

If yes, also complete VA form 21-0960F-1, scars/disfigurement.

If no, provide location and measurements of scar in centimeters.

Location: _____ Measurements: length _____ cm X width _____ cm.

NOTE: If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

12C. Comments, if any:

SECTION IV - DIAGNOSTIC TESTING

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

4A. Have imaging studies or procedures been performed? (For VA purposes, imaging studies are not required for many respiratory conditions)

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

☐	Chest x-ray	Date:		Results:
☐	Magnetic resonance imaging (MRI)	Date:		Results:
☐	Computed tomography (CT)	Date:		Results:
☐	High resolution computed tomography to evaluate interstitial lung disease such as asbestosis (HRCT)	Date:		Results:
☐	Bronchoscopy	Date:		Results:
☐	Biopsy	Date:		Results:
☐	Other, describe: _____	Date:		Results:

4B. Has pulmonary function testing (PFT) been performed?

◯ Yes ◯ No

(If "Yes," do PFT results reported below reflect the Veteran's current pulmonary function?)

◯ Yes ◯ No

Most respiratory conditions require pulmonary function testing, since PFT results represent a major basis for their evaluation. However, pulmonary function testing is not required in all instances. For VA purposes, if the Veteran has any of the following conditions, PFTs are not required. If PFTs have not been completed, indicate reason:

☐ Veteran requires outpatient oxygen therapy

☐ Veteran has had 1 or more episodes of acute respiratory failure

☐ Veteran has been diagnosed with cor pulmonale, right ventricular hypertrophy or pulmonary hypertension

☐ Veteran has had exercise capacity testing and results are 20 ml/kg/min or less

☐ Other, describe: _____

4C. PFT Results

Date of test: _____

Pre-bronchodilator:		Post-bronchodilator, if indicated:	
☐ FVC: _____	% predicted	☐ FVC: _____	% predicted
☐ FEV-1: _____	% predicted	☐ FEV-1: _____	% predicted
☐ FEV-1 /FVC: _____	%	☐ FEV-1 /FVC: _____	%
☐ DLCO: _____	% predicted		

4D. Which test result most accurately reflects the Veteran's level of disability (based on the condition that is being evaluated for this report)? This question is important for VA purposes.

◯ FVC % predicted ◯ FEV-1/FVC

◯ FEV-1 % predicted ◯ DLCO

4E. If post-bronchodilator testing has not been completed, indicate reason:

☐ Pre-bronchodilator results are normal

☐ Not indicated for Veteran's condition

☐ Not indicated in Veteran's particular case (If checked, provide reason): _____

☐ Other, describe: _____

4F. If diffusion capacity of the lung for carbon monoxide by the single breath method (DLCO) testing has not been completed, provide reason:

◯ Not indicated for Veteran's condition

◯ Not indicated in Veteran's particular case

◯ Not valid for Veteran's particular case

◯ Other, describe: _____

4G. Does the Veteran have multiple respiratory conditions?

◯ Yes ◯ No

(If "Yes," list conditions and indicate which condition is predominantly responsible for the limitation in pulmonary function, if any limitation is present):

4H. Has exercise capacity testing been performed?

◯ Yes ◯ No (If "Yes," complete the following):

◯ Maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation)

◯ Maximum oxygen consumption of 15-20 ml/kg/min (with cardiorespiratory limit)

◯ Maximum oxygen consumption of more than 20 ml/kg/min

◯ Unknown results

4I. Are there any other significant diagnostic test findings and/or results?

◯ Yes ◯ No (If "Yes," describe (brief summary)):

SECTION V- 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.

5A. 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 VI - REMARKS

6A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION VII - 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.

7A. Examiner's signature:	7B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

7C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	7D. Date Signed:

7E. Examiner's phone/fax numbers:	7F. National Provider Identifier (NPI) number:	7G. Medical license number and state:

7H. Examiner's address: