Department of Veterans Affairs

THYROID AND PARATHYROID CONDITIONS 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 1 - 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 conditions listed above. (Explain your findings and reasons in the Remarks section)

☐ Hyperthyroidism, including, but not limited to, Graves' disease	ICD code:		Date of diagnosis:	
☐ Thyroid enlargement, toxic	ICD code:		Date of diagnosis:	
☐ Thyroid enlargement, non-toxic	ICD code:		Date of diagnosis:	
☐ Hypothyroidism	ICD code:		Date of diagnosis:	
☐ Hyperparathyroidism	ICD code:		Date of diagnosis:	
☐ Hypoparathyroidism	ICD code:		Date of diagnosis:	
☐ Thyroiditis	ICD code:		Date of diagnosis:	
☐ C-cell hyperplasia	ICD code:		Date of diagnosis:	
☐ Benign neoplasm of the thyroid	ICD code:		Date of diagnosis:	
☐ Malignant neoplasm of the thyroid	ICD code:		Date of diagnosis:	
☐ Benign neoplasm of the parathyroid	ICD code:		Date of diagnosis:	
☐ Malignant neoplasm of the parathyroid	ICD code:		Date of diagnosis:	
☐ 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 thyroid or parathyroid condition(s) list using above format.

SECTION 2 - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the veteran's thyroid and/or parathyroid condition (brief summary).

2B. Has the Veteran had radioactive iodine treatment for a thyroid condition?

◯ Yes ◯ No

(If "Yes", specify the condition treated with radioactive iodine): _____

(Date of treatment): _____

2C. Has the Veteran had any other type of treatment for a thyroid or parathyroid condition?

◯ Yes ◯ No

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

(Date of treatment): _____

Was a prophylactic thyroidectomy performed (based on genetic testing?)

◯ Yes ◯ No

(If "Yes", specify date of surgery): _____

2D. Does the Veteran have any residual endocrine dysfunction following treatment for thyroid or parathyroid condition?

◯ Yes ◯ No

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

☐ Thyroid endocrine dysfunction

☐ Parathyroid endocrine dysfunction

☐ Other (Describe): _____

SECTION 3 - THYROID: FINDINGS, SIGNS, AND SYMPTOMS

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

◯ Yes ◯ No

If "Yes", select the type of thyroid enlargement:

◯ Toxic ◯ Non-toxic

(If "Toxic" is selected, answer questions 3D and 3E. If "Non-toxic" is selected, answer questions 3E and 5B.)

3B. Does the Veteran currently have a diagnosis of thyroiditis?

◯ Yes ◯ No

If "Yes", is the thyroid function normal?

◯ Yes ◯ No

If "No" (the thyroid function is not normal), select the thyroiditis manifestation:

◯ Hypothyroidism ◯ Hyperthyroidism

(If "Hypothyroidism" is selected, answer questions 3C and 3E. If "Hyperthyroidism" is selected, answer questions 3D and 3E.)

3C. Does the Veteran currently have any findings, signs, or symptoms attributable to a hypothyroid condition?

◯ Yes ◯ No (If "Yes", evaluate current residuals with the appropriate questionnaire(s) pertaining to the body system(s) affected as identified in 3E.)

Note: For VA purposes, myxedema, often referred to as myxedema coma or myxedema crisis, is defined as a rare, life-threatening condition from severe hypothyroidism which requires hospitalization for stabilization and may affect several body systems.

Does the Veteran currently have or has the Veteran ever had myxedema (coma or crisis)?

◯ Yes ◯ No

If "Yes", has the myxedema (coma or crisis) stabilized?

◯ Yes ◯ No

If "Yes", provide the date of stabilization as determined by the examining physician:

_____

3D. Does the Veteran currently have any findings, signs, or symptoms attributable to a hyperthyroid condition, including, but not limited to, Graves' disease?

◯ Yes ◯ No (If "Yes", evaluate residuals with the appropriate questionnaire(s) pertaining to the body system(s) affected as identified in 3E.)

3E. Please select the body system(s) affected by the thyroid diagnoses identified in Section 1B:

- ☐ The Veteran does not have current residuals associated with any diagnosed thyroid condition identified above.
- ☐ Musculoskeletal symptoms (complete appropriate musculoskeletal questionnaire)
- ☐ Respiratory/ENT symptoms (complete appropriate respiratory/ENT questionnaire)
- ☐ Cardiovascular symptoms (complete appropriate cardiovascular questionnaire)
- ☐ Gastrointestinal symptoms (complete appropriate gastrointestinal questionnaire)
- ☐ Genitourinary symptoms (complete appropriate genitourinary questionnaire)
- ☐ Reproductive symptoms (complete appropriate gynecological or male reproductive organ questionnaire)
- ☐ Skin symptoms (complete appropriate dermatological questionnaire)
- ☐ Eye involvement (complete appropriate ophthalmological questionnaire)
- ☐ Neurological symptoms (complete appropriate neurological questionnaire)
- ☐ Mental and psychological symptoms (complete appropriate psychological questionnaire)
- ☐ Dental and oral conditions (complete appropriate dental and oral questionnaire)

SECTION 4 - PARATHYROID: FINDINGS, SIGNS, AND SYMPTOMS

4A. Does the Veteran currently have any findings, signs, or symptoms attributable to a hyperparathyroid condition?

◯ Yes ◯ No

Is the condition currently asymptomatic?

◯ Yes ◯ No

Is the Veteran an individual who is not a candidate for surgery but requires continuous medication for control of a hyperparathyroid condition?

◯ Yes ◯ No

Has the Veteran undergone surgery for a hyperparathyroid condition?

◯ Yes ◯ No

(If "Yes", specify type of surgery): _____ (Date of surgery): _____ (Date of discharge following surgery): _____

As a result of hyperparathyroid dysfunction, does the Veteran currently have any of the following symptoms that occur despite surgery?

◯ Yes ◯ No

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

- ☐ Fatigue
- ☐ Anorexia
- ☐ Nausea
- ☐ Constipation

Does the Veteran now have or did the Veteran ever have hypercalcemia that meets the criteria below?

◯ Yes ◯ No

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

- ☐ Hypercalcemia (indicated by bone mineral density T-score less than 2.5 SD (below mean) at any site)
- ☐ Hypercalcemia (indicated by bone mineral density T-score less than 2.5 SD (below mean) at previous fragility fracture)
- ☐ Hypercalcemia (indicated by creatinine clearance less than 60 mL/min)
- ☐ Hypercalcemia (indicated by ionized Ca greater than 5.6mg/dL (2-2.25 mmol/L))

☐ Hypercalcemia (indicated by total Ca greater than 12 mg/dL (3-3.5 mmol/L)

(If "Yes", did the hypercalcemia require pharmacologic treatment?):

◯ Yes ◯ No

(If "Yes", date treatment began): _____

Note: Where surgical intervention is not indicated, six months following when pharmacologic treatment began, please evaluate residuals with the appropriate questionnaire pertaining to the body system affected.

4B. Does the Veteran currently have any findings, signs, or symptoms attributable to a hypoparathyroid condition?

◯ Yes ◯ No

(If "Yes", evaluate residuals with the appropriate questionnaire(s) pertaining to the body system(s) affected as identified in 4C.)

4C. Please select the body system(s) affected by the parathyroid diagnoses identified in Section 1B:

☐ The Veteran does not have current residuals associated with any diagnosed parathyroid condition identified above.

☐ Musculoskeletal symptoms (complete appropriate musculoskeletal questionnaire)

☐ Respiratory symptoms/ENT (complete appropriate respiratory questionnaire)

☐ Cardiovascular symptoms (complete appropriate cardiovascular questionnaire)

☐ Gastrointestinal symptoms (complete appropriate gastrointestinal questionnaire)

☐ Genitourinary symptoms (complete appropriate genitourinary questionnaire)

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

☐ Skin symptoms (complete appropriate dermatological questionnaire)

☐ Eye involvement (complete appropriate ophthalmological questionnaire)

☐ Neurological symptoms (complete appropriate neurological questionnaire)

☐ Mental and psychological symptoms (complete appropriate psychological questionnaire)

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

SECTION 5 - PHYSICAL EXAM

5A. Eyes:

◯ Normal, no exopthalmos ◯ Abnormal (If selected, describe) _____

(If "Abnormal", complete the appropriate ophthalmological questionnaire)

5B. Neck:

☐ Normal, no palpable thyroid enlargement or nodules

☐ Abnormal, enlarged thyroid nodule (if checked, describe location, size and consistency): _____

☐ Abnormal, without disfigurement of the head, face, or neck as a result of treatment for, or due to enlargement of the thyroid gland

☐ Abnormal, with disfigurement of the head, face, or neck as a result of treatment for, or due to enlargement of the thyroid gland

(If checked, answer the following questions)

Is there abnormal pigmentation or texture or missing underlying soft tissue of the head, face, or neck due to the thyroid enlargement?

◯ Yes ◯ No

(If "Yes", check all that apply and provide the approximate combined total area in centimeters squared for each characteristic selected)

☐ Hypopigmentation _____ cm2

☐ Hyperpigmentation _____ cm2

☐ Induration and inflexibility _____ cm2

☐ Abnormal texture _____ cm2

☐ Underlying soft tissue missing _____ cm2

☐ Other (Describe): _____

Is there visible or palpable tissue loss and either gross distortion or asymmetry of facial features as a result of treatment for, or due to enlargement of the thyroid gland?

◯ Yes ◯ No

(If "Yes", identify the feature(s))

☐ Nose ☐ Chin ☐ Forehead ☐ Cheeks ☐ Lips

☐ Eyes (including eyelids) (if checked, specify)

☐ Tissue loss/distortion of eyelid Side: ☐ Right ☐ Left

☐ Tissue loss/distortion of eye Side: ☐ Right ☐ Left

☐ Anatomical loss of eye Side: ☐ Right ☐ Left

☐ Ears (auricles) (if checked, specify)

☐ Complete loss Side: ☐ Right ☐ Left

☐ Loss of one-third or more of the substance Side: ☐ Right ☐ Left

☐ Loss of less than one-third of the substance Side: ☐ Right ☐ Left

For all checked features, provide brief description of the tissue loss, gross distortion and/or asymmetry of facial features:

☐ Other (Describe): _____

5C. Pulse

◯ Regular ◯ Irregular Heart rate: _____

5D. Blood pressure

Blood pressure: _____

SECTION 6 - REFLEX EXAM

6A. Reflexes (Rate deep tendon reflexes (DTRs) according to the following scale):

0 Absent

1+ Hypoactive

2+ Normal

3+ Hyperactive without clonus

4+ Hyperactive with clonus

☐ All normal

BICEPS

Right ◯ 0 ◯ 1+ ◯ 2+ ◯ 3+ ◯ 4+

Left ◯ 0 ◯ 1+ ◯ 2+ ◯ 3+ ◯ 4+

KNEE:

Right	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+
Left	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+

TRICEPS:

Right	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+
Left	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+

ANKLE:

Right	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+
Left	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+

BRACHIORADIALIS:

Right	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+
Left	◯ 0	◯ 1+	◯ 2+	◯ 3+	◯ 4+

SECTION 7 - TUMORS AND NEOPLASMS

7A. 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.

7B. Is the neoplasm:

◯ Benign

◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

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

7C. 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: _____

7D. 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:

7E. 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 8 - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

8A. 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):

8B. 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.

8C. Comments:

SECTION 9 - DIAGNOSTIC TESTING

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

9A. Have clinically relevant imaging studies or other diagnostic procedures been performed or reviewed in conjunction with this examination?

◯ Yes ◯ No

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

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

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

☐ Thyroid scan Date: Results:

☐ Thyroid ultrasound Date: Results:

☐ Other: Date: Results

9B. Has clinically relevant laboratory testing been performed or reviewed in conjunction with this examination?

◯ Yes ◯ No

☐ TSH Date: Results:

☐ Free T4 Date: Results:

☐ Free T3 Date: Results:

☐ Thyroid antibodies Date: Results:

☐ Parathyroid hormone (PTH) Date: Results:

☐ Calcium Date: Results:

☐ Ionized calcium Date: Results:

☐ Other: Date: Results:

9C. Has a biopsy been performed?

◯ Yes ◯ No

Site of biopsy Date of test: Results:

9D. 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):

9E. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

SECTION 10 - 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.

10A. 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 11 - REMARKS

11A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION 12 - 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.

12A. Examiner's signature:	12B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

12C. Examiner's area of practice/specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	12D. Date signed:

12E. Examiner's phone/fax numbers:	12F. National Provider Identifier (NPI) number:	12G. Medical license number and state:

12H. Examiner's address: