



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 now have or has he or she ever been diagnosed with active or latent tuberculosis (TB)?

Yes  No

1B. If no, has the Veteran had a positive skin test for TB without active disease?

Yes  No

1C. If no, has the Veteran had a positive QuantiFERON-TB gold test without active disease?

Yes  No

1D. If yes to either question A, B or C above, provide only diagnoses that pertain to TB conditions:

Diagnosis # 1 - _____	ICD code - _____	Date of diagnosis - _____
Diagnosis # 2 - _____	ICD code - _____	Date of diagnosis - _____
Diagnosis # 3 - _____	ICD code - _____	Date of diagnosis - _____

1E. If there are additional diagnoses that pertain to TB, list using above format:

**SECTION II - MEDICAL HISTORY**

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

2B. Is the Veteran undergoing treatment or has he or she completed treatment for a TB condition, including active TB, positive skin test or laboratory evidence of TB (positive QuantiFERON-TB gold test) without active disease?

Yes     No

If yes, complete the following:

Date treatment began: \_\_\_\_\_

If completed, date of completion: \_\_\_\_\_

If not completed, anticipated date of completion: \_\_\_\_\_

2C. List medications currently or previously used for treatment of TB condition:

**SECTION III - PULMONARY TB**

3A. Does the Veteran now have or has he or she ever been diagnosed with pulmonary tuberculosis?

Yes     No

If yes, is the condition:

Active

Inactive

If inactive, date condition became inactive: \_\_\_\_\_

3B. Does the Veteran have any residual findings, signs and/or symptoms due to pulmonary TB?

Yes  No

If yes, indicate residuals:

- Emphysema
- Dyspnea on exertion
- Requires oxygen therapy
- Episodes of acute respiratory failure
- Moderately advanced lesions
- Far advanced lesions (diagnosed at any time while the disease process was active)
- Pulmonary hypertension
- Right ventricular hypertrophy
- Cor pulmonale (right heart failure)
- Impairment of health

If checked, describe: \_\_\_\_\_

Other, describe: \_\_\_\_\_

3C. Has the Veteran had thoracoplasty due to TB?

Yes  No Date of procedure: \_\_\_\_\_

If yes, has the Veteran had resection of any ribs incident to thoracoplasty?

Yes  No

If yes, indicate number of ribs involved:  1  2  3 or 4  5 or 6  More than 6

**SECTION IV - NON-PULMONARY TB**

4A. Does the Veteran now have or has he or she ever been diagnosed with non-pulmonary tuberculosis?

Yes  No

If yes, check all non-pulmonary TB conditions that apply:

- Tuberculous pleurisy
- Tuberculous peritonitis
- Tuberculosis meningitis
- Laryngitis, tuberculous
- Skeletal TB
- Genitourinary TB
- Gastrointestinal TB
- Tuberculous lymphadenitis
- Cutaneous TB
- Ocular TB
- Other, describe: \_\_\_\_\_

4B. For all checked conditions, indicate whether the condition is active or inactive; if inactive, provide date condition became inactive:

4C. Does the Veteran have any residuals from any of the non-pulmonary TB conditions?

Yes

No

If yes, describe: Also complete appropriate questionnaires for the specific residual conditions.

**SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS**

5A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?

Yes

No

If yes, describe (brief summary):

5B. 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?

Yes

No

If "Yes," are any of these scars painful and/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 the Comments Section below. It is not necessary to also complete a Scars DBQ.

5C. Comments, if any:

**SECTION VI - DIAGNOSTIC TESTING**

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

6A. Have imaging studies or procedures been performed?

Yes  No

If yes, check all that apply:

- Chest x-ray Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Magnetic resonance imaging (MRI) Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Computerized axial tomography (CT) Date: \_\_\_\_\_ Results: \_\_\_\_\_
- High resolution computed tomography to evaluate interstitial lung disease such as asbestosis (HRCT) Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Other, specify: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

6B. 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

6C. Pulmonary function testing is not required in all instances. If PFTs have not been completed, provide 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: \_\_\_\_\_

6D. PFT results

Date: \_\_\_\_\_

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

6E. Which test result most accurately reflects the Veteran's current pulmonary function?

- FEV-1
- FEV-1/FVC
- FVC
- DLCO

6F. If post-bronchodilator testing has not been completed, provide reason:

- Pre-bronchodilator results are normal
- Post-bronchodilator testing not indicated for Veteran's condition
- Post-bronchodilator testing not indicated in Veteran's particular case

If checked, provide reason:

Other, describe: \_\_\_\_\_

6G. 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: \_\_\_\_\_

6H. 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:

6I. 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 cardiac or respiratory limit)

6J. Are there any other significant diagnostic test findings and/or results?

- Yes
- No

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

### SECTION VII - FUNCTIONAL IMPACT

7A. Does the Veteran's tuberculosis condition impact his or her ability to work?

- Yes
- No

If yes, describe impact of each of the Veteran's tuberculosis conditions, providing one or more examples:

**SECTION VIII - REMARKS**

8A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

**SECTION IX - 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.

9A. Examiner's signature: _____	9B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C): _____	
9C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice): _____	9D. Date Signed: _____	
9E. Examiner's phone/fax numbers: _____	9F. National Provider Identifier (NPI) number: _____	9G. Medical license number and state: _____
9H. Examiner's address: _____ _____		