



NON-DEGENERATIVE ARTHRITIS (INCLUDING INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE AND INFECTIOUS) AND DECOMPRESSION ILLNESS DISABILITY BENEFITS QUESTIONNAIRE

Name of Claimant/Veteran:

Claimant/Veteran's Social Security Number:

Date of Examination:

[Empty text box for Name of Claimant/Veteran]

[Empty text box for Social Security Number]

[Empty text box for 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 questionnaires completed by providers. It is intended that this questionnaire will be completed by the Veteran's provider.

Are you completing this Disability Benefits Questionnaire at the request of:

Veteran/Claimant

Other: please describe

[Empty text box for description of other requestor]

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?

[Empty text box for examination method]

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.

[Empty text box for evidence reviewed]

DOMINANT HAND

Dominant hand: Right Left Ambidextrous

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 conditions 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, 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 at the end of this questionnaire.)

SECTION I - DIAGNOSIS (continued)

<input type="checkbox"/> Multi-joint arthritis (except post-traumatic and gout), 2 or more joints, as an active process (conditions include, but are not limited to, rheumatoid arthritis, psoriatic arthritis, and spondyloarthropathies) - Please specify diagnosis(es): _____	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> Arthritis, gonorrheal	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> Arthritis, pneumococccic	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> Arthritis, typhoid	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> Arthritis, syphilitic	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> Arthritis, streptococccic	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> Decompression illness (previously dysbaric osteocrenosis/caisson disease)	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> Other specified forms of arthropathy (excluding gout) (conditions include, but are not limited to, Charcot neuropathic, hypertrophic, crystalline, and other autoimmune arthropathies) - Please specify diagnosis: _____	ICD Code: _____	Date of diagnosis: _____
<input type="checkbox"/> Other (specify): If checked, provide only diagnoses that pertain to inflammatory, autoimmune, crystalline or infectious arthritis. Other diagnosis #1 _____	ICD Code: _____	Date of diagnosis: _____
Other diagnosis #2 _____	ICD Code: _____	Date of diagnosis: _____
Other diagnosis #3 _____	ICD Code: _____	Date of diagnosis: _____

If there are additional diagnoses that pertain to non-degenerative arthritis conditions, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's inflammatory, autoimmune, crystalline or infectious arthritis, or decompression illness (brief summary):

2B. Does the Veteran require continuous use of medication for the arthritis condition? Yes No

If yes, list only those medications used for this arthritis condition:

2C. Has the Veteran lost weight due to the arthritis condition? Yes No

If yes, provide baseline weight (average weight for 2-year period preceding onset of disease): _____ and current weight: _____

If yes, does the Veteran's weight loss (attributable to the arthritis condition) cause impairment of health? Yes No

If yes, describe the impairment:

2D. Does the Veteran have anemia due to the arthritis condition? Yes No

If yes, does the Veteran's anemia (which is attributable to the arthritis condition) cause impairment of health? Yes No

If yes, describe the impairment, and also provide Complete Blood Count (CBC) under Section IX - Diagnostic Testing:

SECTION III - JOINT INVOLVEMENT

Note: If joint involvement (e.g., pain, limitation of motion, joint deformity) is present, complete the appropriate questionnaire for each identified joint. Also complete the appropriate questionnaire for each affected body system, if indicated.

3A. Does the Veteran have any joint involvement (e.g., pain, limitation of motion, joint deformity) attributable to the arthritis condition? Yes No

If yes, indicate affected joints. Check all that apply:

Cervical spine Thoracolumbar spine Sacroiliac joints

Right: Shoulder Elbow Wrist Hand/fingers Hip Knee Ankle Foot/toes

Left: Shoulder Elbow Wrist Hand/fingers Hip Knee Ankle Foot/toes

For all checked joints, describe involvement (brief summary):

SECTION IV - SYSTEMIC INVOLVEMENT OTHER THAN JOINTS

4A. Does the Veteran have any involvement of any body systems, other than joints, attributable to the arthritis condition? Yes No

If yes, indicate systems involved. Check all that apply.

Ophthalmological Skin and mucous membranes Hematological Pulmonary Cardiac
 Neurological Renal Gastrointestinal Vascular Other

For all checked systems, describe involvement (brief summary). Also complete the appropriate questionnaire for each affected body system, if indicated.

4B. Comments (if any):

SECTION V - INCAPACITATING AND NON-INCAPACITATING EXACERBATIONS

5A. Due to the arthritis condition, does the Veteran have exacerbations which are not incapacitating? Yes No

If yes, indicate frequency of non-incapacitating exacerbations per year (on average):

0 1 2 3 4 or more

Date of most recent non-incapacitating exacerbation: _____

Duration of most recent non-incapacitating exacerbation: _____

Describe non-incapacitating exacerbation: _____

5B. Due to the arthritis condition, does the Veteran have exacerbations which are incapacitating? Yes No

If yes, indicate frequency of incapacitating exacerbations per year (on average):

0 1 2 3 4 or more

Indicate the total duration of incapacitation over the past 12 months:

< 1 week
 1 week to < 2 weeks
 2 weeks to < 4 weeks
 4 weeks to < 6 weeks
 6 weeks or more

Date of most recent incapacitating exacerbation: _____

Duration of most recent incapacitating exacerbation: _____

Describe incapacitating exacerbation: _____

SECTION V - INCAPACITATING AND NON-INCAPACITATING EXACERBATIONS (continued)

5C. Is the Veteran's arthritis manifested by constitutional manifestations associated with active joint involvement which are totally incapacitating? Yes No

5D. Is the Veteran's arthritis manifested by weight loss and anemia productive of severe impairment of health? Yes No

5E. Is the Veteran's arthritis manifested by severely incapacitating exacerbations occurring four or more times a year, or a lesser number over prolonged periods? Yes No

5F. Is the Veteran's arthritis manifested by symptom combinations productive of definite impairment of health, objectively supported by examination findings? Yes No

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

6A. 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):

6B. 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.

SECTION VII - ASSISTIVE DEVICES

7A. Does the Veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible? Yes No

If yes, identify the assistive devices used. Check all that apply and indicate frequency:

- | | | | | |
|---------------------------------------|-------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Wheelchair | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Brace(s) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Crutch(es) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Cane(s) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Walker | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Other: _____ | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |

7B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition:

SECTION VIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

Note: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prosthesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

8A. Due to the Veteran's arthritis condition, is there functional impairment of an extremity such that no effective function remains, other than that which would be equally well-served by an amputation with prosthesis? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance, propulsion, etc.)

Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran

No

If yes, indicate extremities for which this applies: Right upper Left upper Right lower Left lower

8B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

SECTION IX - DIAGNOSTIC TESTING

Note: Testing listed below is not indicated for every condition.

9A. Have imaging studies been performed in conjunction with this examination? Yes No

Was arthritis documented? Yes No

If yes, indicate type of study:

X-ray Area(s) imaged: _____ Date: _____ Results: _____

Other, specify: _____ Area(s) imaged: _____ Date: _____ Results: _____

9B. Have laboratory studies been performed? Yes No If yes, check all that apply:

Erythrocyte sedimentation rate (ESR) Date of test: _____ Results: _____

C-reaction protein Date of test: _____ Results: _____

Rheumatoid factor (RF) Date of test: _____ Results: _____

Anti-DNA antibodies Date of test: _____ Results: _____

Antinuclear antibodies (ANA) Date of test: _____ Results: _____

Anti-cyclic citrullinated peptide (ANTI - CCP) antibodies Date of test: _____ Results: _____

CBC Date of test: _____

Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____

Uric acid test Date of test: _____ Results: _____

Other, specify: _____ Date of test: _____ Results: _____

If any test results in this section are other than normal, include normal reference ranges for your facility.

9C. Has the Veteran had a joint aspiration or synovial fluid analysis? Yes No If yes, indicate joint aspirated, date and results:

9D. Has the Veteran had a biopsy? Yes No If yes, indicate area biopsied, date and results:

9E. Are there any other significant 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):

9F. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed condition(s):

SECTION X - 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 XI - REMARKS

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

SECTION XII - EXAMINER'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

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: