



HEART CONDITIONS (INCLUDING ISCHEMIC AND NON-ISCHEMIC HEART DISEASE, ARRHYTHMIAS, VALVULAR DISEASE AND CARDIAC SURGERY) DISABILITY BENEFITS QUESTIONNAIRE

Name of Claimant/Veteran: <input type="text"/>	Claimant/Veteran's Social Security Number: <input type="text"/>	Date of Examination: <input type="text"/>
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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

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):

- |                          |   |           |                    |
|--------------------------|---|-----------|--------------------|
| <input type="checkbox"/> | 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) |           |                    |
| <input type="checkbox"/> | Acute, subacute, or old myocardial infarction   | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Atherosclerotic cardiovascular disease  | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Unstable angina   | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Stable angina   | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Arteriosclerotic heart disease (Coronary artery disease)  | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Coronary spasm, including Prinzmetal's angina   | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Congestive heart failure  | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Bradycardia (bradyarrhythmia)   | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Ventricular arrhythmia  | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Supraventricular arrhythmia (supraventricular tachycardia)  | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Automatic implantable cardioverter defibrillator (AICD)   | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Implanted cardiac pacemaker   | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Cardiac/Heart transplant  | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Valvular heart disease  | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Heart block   | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Other infectious heart conditions   | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Hyperthyroid heart disease (if checked also complete the Thyroid/Parathyroid questionnaire)   | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Syphilitic heart disease  | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Pericarditis  | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Endocarditis  | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Rheumatic heart disease   | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Active valvular infection   | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Coronary artery bypass graft  | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Heart valve replacement (prosthesis)  | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Cardiomyopathy  | ICD Code: | Date of diagnosis: |
| <input type="checkbox"/> | Hypertensive heart disease  | ICD Code: | Date of diagnosis: |

<input type="checkbox"/> Pericardial adhesions	ICD Code:	Date of diagnosis:
<input type="checkbox"/> Other heart condition (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:

If there are additional diagnoses that pertain to heart conditions, list using above format:

**SECTION II - MEDICAL HISTORY**

2A. Describe the history (including onset and course) of the Veteran's heart condition (brief summary):

2B. Do any of the Veteran's heart conditions qualify within the generally accepted medical definition of Ischemic Heart Disease (IHD)?

Yes     No

If yes, list the conditions that qualify:

2C. Provide the etiology, if known, of each of the Veteran's heart conditions, including the relationship/causality to other heart conditions, particularly the relationship/causality to the Veteran's IHD conditions, if any:

Heart condition #1 (provide etiology):

Heart condition #2 (provide etiology):

If there are additional heart conditions, list and provide etiology, using above format:

2D. Is continuous medication required for control of the Veteran's heart condition?       Yes     No

If yes, list the medications required for the Veteran's heart condition (include name of medication and heart condition it is used for; such as Atenolol for myocardial infarction or atrial fibrillation)

**SECTION III - MYOCARDIAL INFARCTION (MI)**

3A. Has the Veteran had an MI?       Yes     No      If yes, complete the following:

MI #1 Date and treatment facility:

MI #2 Date and treatment facility:

If the Veteran has had additional MIs, list using above format:

**SECTION IV - ARRHYTHMIA**

4A. Has the Veteran had a cardiac arrhythmia?       Yes       No      If yes, complete the following:

Note: A treatment intervention occurs whenever a symptomatic patient requires intravenous pharmacologic adjustment, cardioversion, and/or ablation for symptom relief.

- Asymptomatic bradycardia (bradyarrhythmia)
  
- Bradycardia (bradyarrhythmia), symptomatic, requiring permanent pacemaker implantation
  
- Supraventricular tachycardia documented by electrocardiogram (ECG) (if checked, indicate type of treatment)
  - Treatment intervention (specify the type and number of treatment interventions per year)
    - Intravenous pharmacologic adjustment       Cardioversion       Ablation for symptom relief
    - 0       1-4       5 or more
  
  - Continuous use of oral medications to control
  
  - Use of vagal maneuvers to control
  
  - No treatment
  
- Atrioventricular block (if checked, select type)
  - First degree       Second degree (type I)       Second degree (type II)       Third degree
  
- Ventricular arrhythmia (sustained) (Indicate date of hospital admission for initial evaluation and medical treatment in Section VIII - Procedures)
  
- Other cardiac arrhythmia,  (if checked, indicate type of treatment)  
specify:
  - Treatment intervention (specify the type and number of treatment interventions per year)
    - Intravenous pharmacologic adjustment       Cardioversion       Ablation for symptom relief
    - 0       1-4       5 or more
  
  - Continuous use of oral medications to control
  
  - Use of vagal maneuvers to control
  
  - No treatment

**SECTION V - HEART VALVE CONDITIONS**

5A. Has the Veteran had a heart valve condition?       Yes       No      If yes, complete the following:

Heart valves affected. Check all that apply:       Mitral       Tricuspid       Aortic       Pulmonary

Describe the type of valve condition for each checked valve.

**SECTION VI - INFECTIOUS HEART CONDITIONS**

6A. Has the Veteran had any infectious cardiac conditions, including active valvular infection (which includes rheumatic heart disease), endocarditis, pericarditis, or syphilitic heart disease?  Yes  No

6B. Has the Veteran undergone or is the Veteran currently undergoing treatment for any active infection?  Yes  No

If yes, describe treatment and site of infection being treated. Also provide date or expected date of completion

\_\_\_\_\_

Date completed: \_\_\_\_\_ Expected date of completion: \_\_\_\_\_

6C. Has the Veteran had a syphilitic aortic aneurysm?  Yes  No If yes, complete the Artery and Vein Questionnaire.

### SECTION VII - PERICARDIAL ADHESIONS

7A. Has the Veteran had pericardial adhesions?  Yes  No If yes, complete the following:

Etiology of pericardial adhesions:  Pericarditis  Cardiac surgery/bypass  Other, describe: \_\_\_\_\_

### SECTION VIII - PROCEDURES

8A. Has the Veteran had any non-surgical or surgical procedures for the treatment of a heart condition?  Yes  No

If yes, indicate the non-surgical or surgical procedures the Veteran has had for the treatment of a heart condition. Check all that apply:

Percutaneous coronary intervention (PCI) (angioplasty) Date of treatment: \_\_\_\_\_ Date of admission: \_\_\_\_\_

Indicate treatment facility: \_\_\_\_\_

Indicate the condition that resulted in the need for the procedure/treatment: \_\_\_\_\_

Coronary artery bypass surgery Date of treatment: \_\_\_\_\_ Date of admission: \_\_\_\_\_

Indicate treatment facility: \_\_\_\_\_

Indicate the condition that resulted in the need for the procedure/treatment: \_\_\_\_\_

Cardiac/Heart transplants Date of treatment: \_\_\_\_\_ Date of admission: \_\_\_\_\_ Date of discharge: \_\_\_\_\_

Indicate treatment facility: \_\_\_\_\_

Indicate the condition that resulted in the need for the procedure/treatment: \_\_\_\_\_

Implanted cardiac pacemaker Date of treatment: \_\_\_\_\_ Date of admission: \_\_\_\_\_ Date of discharge: \_\_\_\_\_

Indicate treatment facility: \_\_\_\_\_

Indicate the condition that resulted in the need for the procedure/treatment: \_\_\_\_\_

Automatic implantable cardioverter defibrillator (AICD) Date of treatment: \_\_\_\_\_ Date of admission: \_\_\_\_\_

Indicate treatment facility: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

Indicate the condition that resulted in the need for the procedure/treatment: \_\_\_\_\_

Heart valve replacement (prosthesis) (if checked indicate valve(s) that have been replaced (check all that apply)):

Mitral  Tricuspid  Aortic  Pulmonary

Date of treatment: \_\_\_\_\_ Date of admission: \_\_\_\_\_ Date of discharge: \_\_\_\_\_

Indicate treatment facility: \_\_\_\_\_

Indicate the condition that resulted in the need for the procedure/treatment: \_\_\_\_\_

Ventricular aneurysmectomy      Date of treatment: \_\_\_\_\_      Date of admission: \_\_\_\_\_      Date of discharge: \_\_\_\_\_

Indicate treatment facility: \_\_\_\_\_

Indicate the condition that resulted in the need for the procedure/treatment: \_\_\_\_\_

Other surgical and/or non surgical procedures for the treatment of a heart condition, describe: \_\_\_\_\_

Date of treatment: \_\_\_\_\_      Date of admission: \_\_\_\_\_      Date of discharge: \_\_\_\_\_

Indicate treatment facility: \_\_\_\_\_

Indicate the condition that resulted in the need for the procedure/treatment: \_\_\_\_\_

8B. If the Veteran has had additional non-surgical or surgical procedures for the treatment of a heart condition, list using above format:

### SECTION IX - HOSPITALIZATIONS

9A. Has the Veteran had any other hospitalizations for the treatment of a heart condition (other than for non-surgical and/or surgical procedures described above)?

Yes     No    If yes, complete the following:

Date of admission: \_\_\_\_\_      Date of discharge: \_\_\_\_\_

Indicate treatment facility: \_\_\_\_\_

Condition that resulted in the need for hospitalization: \_\_\_\_\_

### SECTION X - PHYSICAL EXAMINATION

10A. Physical examination findings:

Heart rate: \_\_\_\_\_      Blood pressure: \_\_\_\_\_

Rhythm:     Regular       Irregular

Point of maximal impact:     Not palpable       4th intercostal space       5th intercostal space       Other, specify: \_\_\_\_\_

Heart sounds:     Normal       Abnormal, specify: \_\_\_\_\_

Jugular-venous distension:     Yes     No

Auscultation of the lungs:     Clear     Bibasilar rales     Other, specify: \_\_\_\_\_

Peripheral pulses:

Dorsalis pedis:     Normal     Diminished     Absent

Posterior tibial:     Normal     Diminished     Absent

Peripheral edema:

Right lower extremity:     None     Trace     1+     2+     3+     4+

Left lower extremity:     None     Trace     1+     2+     3+     4+

### SECTION XI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

11A. 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):

11B. 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 XII - DIAGNOSTIC TESTING**

Note: For VA purposes, exams for all heart conditions require a determination of whether or not cardiac hypertrophy or dilatation (documented by electrocardiogram, echocardiogram, or x-ray) is present. The suggested order of testing for cardiac hypertrophy/dilatation is ECG, then chest x-ray (PA and lateral), and then echocardiogram. An echocardiogram to determine heart size is only necessary if the other two tests are negative.

12A. Is there evidence of cardiac hypertrophy?     Yes     No    If yes, indicate how this condition was documented.

ECG     Chest x-ray     Echocardiogram     Multigated Acquisition Scan (MUGA)     MRI    Date of test: \_\_\_\_\_

12B. Is there evidence of cardiac dilatation?     Yes     No    If yes, indicate how this condition was documented.

ECG     Chest x-ray     Echocardiogram     MUGA     MRI    Date of test: \_\_\_\_\_

12C. Select all testing completed and provide most recent results which reflect the Veteran's current functional status. Check all that apply:

ECG

Date of ECG: \_\_\_\_\_    Results of ECG:     Normal  
 Arrhythmia, describe: \_\_\_\_\_  
 Ischemic, describe: \_\_\_\_\_  
 Other, describe: \_\_\_\_\_

Chest x-ray

Date of Chest x-ray: \_\_\_\_\_    Results of chest x-ray:     Normal  
 Abnormal, describe: \_\_\_\_\_

Echocardiogram

Date of echocardiogram: \_\_\_\_\_    Wall motion:     Normal  
 Abnormal, describe: \_\_\_\_\_  
  
Wall thickness:     Normal  
 Abnormal, describe: \_\_\_\_\_

MUGA

Date of MUGA: \_\_\_\_\_    Results of MUGA     Normal  
 Abnormal, describe: \_\_\_\_\_

Coronary artery angiogram

Date of angiogram: _____	Results of angiogram	<input type="checkbox"/> Normal	
		<input type="checkbox"/> Abnormal, describe:	_____
<input type="checkbox"/> CT angiography			
Date of CT angiography: _____	Results of CT	<input type="checkbox"/> Normal	
		<input type="checkbox"/> Abnormal, describe:	_____
<input type="checkbox"/> Other test			
		Other test, specify	_____
Date of test: _____	Results of test	<input type="checkbox"/> Normal	
		<input type="checkbox"/> Abnormal, describe:	_____

**SECTION XIII - METABOLIC EQUIVALENTS (METs) TESTING**

Note: For VA purposes, all heart exams require METs testing (either exercise-based or interview-based) to determine the activity level at which symptoms such as breathlessness, fatigue, angina, dizziness, or syncope develops (except exams for supraventricular arrhythmias). If a laboratory determination for METs by exercise testing cannot be done for medical reasons, then perform an interview-based METs test based on the Veteran's responses to a cardiac activity questionnaire and provide the results below.

13A. Select all testing completed (of record and/or completed during this examination) and provide the most recent results that reflect the Veteran's current functional status. Check all that apply:

- Exercise stress test     
 Interview-based METs test     
 None

13B. Exercise stress test

Date of most recent exercise stress test: \_\_\_\_\_ Results: \_\_\_\_\_

METs level the Veteran performed, if provided: \_\_\_\_\_

Did the test show ischemia?       Yes     No      If no, was the test terminated due to symptoms related to the cardiac condition?

Yes, the test was terminated due to symptoms related to the cardiac condition.

No, the test was terminated due to symptoms not related to the cardiac condition. Please provide the reason for termination below: (Examiner also needs to complete questions 13C through 13F.)

13C. If an exercise stress test was not performed, select a reason.

Veteran has a medical contraindication, describe:

Veteran's previous exercise stress test reflects current cardiac function.

Exercise stress testing is not required as part of the Veteran's current treatment plan and this test is not without significant risk.

Other, describe:

13D. Interview-based METs test

Date of interview-based METs test: \_\_\_\_\_



Symptoms during activity: The METs level checked below reflects the lowest activity level at which the Veteran reports any of the following symptoms (check all symptoms that the Veteran reports at the indicated METs level of activity):

The Veteran denies experiencing symptoms attributable to a cardiac condition with any level of physical activity

Breathlessness

Fatigue

Angina

Dizziness

Syncope

Other, describe:

Results of interview-based METs test. METs level on most recent interview-based METs test:

(1-3 METs) This METs level has been found to be consistent with activities such as eating, dressing, taking a shower, slow walking (2mph) for 1-2 blocks

(>3-5 METs) This METs level has been found to be consistent with activities such as light yard work (weeding), mowing lawn (power mower), brisk walking (4 mph)

(>5-7 METs) This METs level has been found to be consistent with activities such as walking 1 flight of stairs, golfing (without cart), mowing lawn (push mower), heavy yard work (digging)

(>7-10 METs) This METs level has been found to be consistent with activities such as climbing stairs quickly, moderate bicycling, sawing wood, jogging (6 mph)

13E. Has the Veteran had both an exercise stress test and interview-based METs test?  Yes  No

If yes, indicate which results most accurately reflect the Veteran's current cardiac functional level.

Exercise stress test

Interview-based METs test

13F. Is the METs level provided due solely to the heart condition(s) that the Veteran is claiming in the diagnosis section?  Yes  No If no, complete question 13G.

13G. What is the estimated interview-based METs level due solely to the cardiac condition(s) listed above? If this is different than the METs level reported above because of comorbid conditions, provide METs level for the claimed cardiac condition only and rationale below.

Results of interview-based METs test. METs level on most recent interview-based METs test:

(1-3 METs) This METs level has been found to be consistent with activities such as eating, dressing, taking a shower, slow walking (2mph) for 1-2 blocks

(>3-5 METs) This METs level has been found to be consistent with activities such as light yard work (weeding), mowing lawn (power mower), brisk walking (4 mph)

(>5-7 METs) This METs level has been found to be consistent with activities such as walking 1 flight of stairs, golfing (without cart), mowing lawn (push mower), heavy yard work (digging)

(>7-10 METs) This METs level has been found to be consistent with activities such as climbing stairs quickly, moderate bicycling, sawing wood, jogging (6 mph)

Rationale:

#### SECTION XIV - 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.

14A. 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 XV - REMARKS

15A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

#### SECTION XVI - EXAMINER'S CERTIFICATION AND SIGNATURE

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

16A. Examiner's signature:

16B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

