Department of Veterans Affairs

HYPERTENSION 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

1A. DOES THE VETERAN CURRENTLY HAVE A DIAGNOSIS OF HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION BASED ON THE FOLLOWING CRITERIA?
NOTE 1: For VA disability rating purposes, the term hypertension means that the diastolic blood pressure is predominantly 90mm or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm or greater with a diastolic blood pressure of less than 90mm.
NOTE 2: For VA purposes, the INITIAL diagnosis of hypertension or isolated systolic hypertension must be confirmed by readings taken 2 or more times on at least 3 different days. Blood pressure results may be obtained from existing medical records or through scheduled visits for blood pressure measurements.

◯ Yes ◯ No (If yes, provide only diagnoses that pertain to hypertension):

☐ Hypertension ICD code: _____ Date of diagnosis _____

☐ Isolated systolic hypertension ICD code: _____ Date of diagnosis _____

☐ OTHER (Specify):

OTHER DIAGNOSIS #1: _____ ICD code: _____ Date of diagnosis: _____

OTHER DIAGNOSIS #2: _____ ICD code: _____ Date of diagnosis: _____

1B. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION, LIST USING ABOVE FORMAT:

NOTE 3: ALSO complete appropriate questionnaires for hypertension-related complications, if any (such as Kidney, if renal insufficiency is attributable to hypertension).

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (INCLUDING ONSET AND COURSE) OF THE VETERAN'S HYPERTENSION CONDITION (Brief summary):

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION?

◯ Yes ◯ No

(If yes, list only those medications used for the diagnosed conditions): _____

2C. WAS THE VETERAN'S INITIAL DIAGNOSIS OF HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION CONFIRMED BY BLOOD PRESSURE READINGS TAKEN 2 OR MORE TIMES ON AT LEAST 3 DIFFERENT DAYS?

◯ Yes ◯ No ◯ Unknown (If checked, proceed to questions 2D and 2E)

(If yes, provide BP readings used to establish initial diagnosis, if known)

Reading #1: ___ / ___	Reading # 2: ___ / ___	Date of Reading: ___
Reading #1: ___ / ___	Reading # 2: ___ / ___	Date of Reading: ___
Reading #1: ___ / ___	Reading # 2: ___ / ___	Date of Reading: ___

(If no, report BP readings taken 2 or more times on at least 3 different days in order to confirm diagnosis (unless Veteran is on treatment for hypertension.))

Reading #1: ___ / ___	Reading # 2: ___ / ___	Date of Reading: ___
Reading #1: ___ / ___	Reading # 2: ___ / ___	Date of Reading: ___
Reading #1: ___ / ___	Reading # 2: ___ / ___	Date of Reading: ___

2D. DOES THE VETERAN HAVE A HISTORY OF A DIASTOLIC BP ELEVATION TO PREDOMINANTLY 100 OR MORE?

◯ Yes ◯ No (If yes, describe frequency and severity of diastolic BP elevation):

2E. CURRENT (DATE OF EVALUATION/S) BLOOD PRESSURE READINGS** (SUFFICIENT IF VETERAN HAS A PREVIOUSLY ESTABLISHED DIAGNOSIS OF HYPERTENSION):
**The Veteran should be seated comfortably with back and feet supported. There is no need to take lying or standing blood pressures. There is no specified time interval between readings and they may be completed sequentially.

Reading #1:	_____	/	_____	Date of Reading: _____
Reading #2:	_____	/	_____	Date of Reading: _____
Reading #3:	_____	/	_____	Date of Reading: _____

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

3A. 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):

3B. 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, also complete appropriate dermatological DBQ)

3C. COMMENTS, IF ANY:

SECTION IV - FUNCTIONAL IMPACT

4A. DOES THE VETERAN'S HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION IMPACT HIS OR HER ABILITY TO WORK?

◯ Yes ◯ No

(If yes, describe the impact of the veteran's hypertension or isolated systolic hypertension, providing one or more examples):

SECTION V - REMARKS

5A. REMARKS (IF ANY):

SECTION VI - 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.

6A. Examiner's signature:	6B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

6C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	6D. Date Signed:

6E. Examiner's phone/fax numbers:	6F. National Provider Identifier (NPI) number:	6G. Medical license number and state:

6H. Examiner's address: