Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
BREAST CONDITIONS AND DISORDERS DISABILITY BENEFITS QUESTIONNAIRE

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

NOTE TO PHYSICIAN - Your patient 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.

IS THIS DBQ BEING COMPLETED IN CONJUNCTION WITH A VA 21-2507, C&P EXAMINATION REQUEST?

☐ YES ☐ NO

If no, how was the examination completed (check all that apply)?

☐ In-person examination
☐ Records reviewed
☐ Other, please specify:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the DBQ and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with a telephone interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with a telephone interview provided sufficient information on which to prepare the DBQ and such an examination would likely provide no additional relevant evidence.

☐ Examination via approved video telehealth

☐ In-person examination

EVIDENCE REVIEW

EVIDENCE REVIEWED *(check all that apply):*

☐ Not requested
☐ VA claims file (hard copy paper C-file)
☐ VA e-folder
☐ CPRS
☐ Other (please identify other evidence reviewed):

☐ No records were reviewed

EVIDENCE COMMENTS:

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER HAD A DISORDER OF THE BREAST(S)?

☐ YES ☐ NO

1B. IF YES, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO THE BREAST(S)

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO THE BREAST(S), LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S BREAST CONDITION*:*

2B. DOES THE VETERAN HAVE, OR HAVE A HISTORY, OF A NEOPLASM OF THE BREAST?

☐ YES ☐ NO

2C. IF YES, IS OR WAS THERE A MALIGNANT NEOPLASM OF THE BREAST?

☐ YES ☐ NO *(If "Yes," indicate which breast):* ☐ RIGHT ☐ LEFT ☐ BOTH

(If "Yes," is the malignancy active?): ☐ YES ☐ NO, WATCHFUL WAITING

(If "Yes," were there or are there currently any metastases?): ☐ YES ☐ NO

(If "Yes," describe locations): _____

2D. IF YES, IS OR WAS THERE A BENIGN NEOPLASM?

☐ YES ☐ NO

(If "Yes," indicate which breast): ☐ RIGHT ☐ LEFT ☐ BOTH

SECTION III - TREATMENT/SURGERY

3A. HAS THE VETERAN COMPLETED ANY TYPE OF TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM AND/OR METASTASES?

☐ YES ☐ NO; WATCHFUL WAITING

(If "Yes," indicate treatment type(s) - check all that apply):

☐ Treatment completed; currently in watchful waiting status

☐ Undergoing surgical, X-Ray, antiseptic chemotherapy or other therapeutic procedure

☐ 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: _____

Side ☐ RIGHT ☐ LEFT ☐ BOTH

☐ Antineoplastic chemotherapy

Date of most recent treatment: _____

Date of completion of treatment or anticipated date of completion: _____

☐ Other therapeutic procedure and/or treatment *(describe):* _____

Date of procedure: _____

Date of completion of treatment or anticipated date of completion: _____

Describe the other treatment and/or procedure:

SECTION III - TREATMENT/SURGERY *(Continued)*

3B. HAS THE VETERAN UNDERGONE BREAST SURGERY?

☐ YES ☐ NO

(If "Yes," indicate procedure type and severity (check all that apply)):

☐ Wide local excision *(For VA purposes, wide local excision means removal of a portion of the breast tissue and includes partial mastectomy, lumpectomy, tylectomy, segmentectomy, and quadrantectomy)*

☐ Significant alteration of form	☐ Right	☐ Left	☐ Both	
☐ Significant alteration of size	☐ Right	☐ Left	☐ Both	
☐ Without significant alteration of form	☐ Right	☐ Left	☐ Both	
☐ Without significant alteration of size	☐ Right	☐ Left	☐ Both	

☐ Simple *(or total)* mastectomy *(For VA purposes, a simple (or total) mastectomy means removal of all of the breast tissue, nipple, and a small portion of the overlying skin, but lymph nodes and muscles are left intact)*

☐ Significant alteration of form	☐ Right	☐ Left	☐ Both
☐ Significant alteration of size	☐ Right	☐ Left	☐ Both

☐ Modified radical mastectomy *(For VA purposes, a modified radical mastectomy means removal of the entire breast and axillary lymph nodes, in continuity with the breast, with pectoral muscles left intact)*

☐ Right ☐ Left ☐ Both

☐ Radical mastectomy *(For VA purposes, radical mastectomy means removal of the entire breast, underlying pectoral muscles, and regional lymph nodes up to the coracoclavicular ligament)*

☐ Right ☐ Left ☐ Both

☐ Axillary or sentinel lymph node excision	☐ Right	☐ Left	☐ Both
☐ Significant alteration of size or form	☐ Right	☐ Left	☐ Both
☐ Biopsy	☐ Right	☐ Left	☐ Both
☐ Other: _____	☐ Right	☐ Left	☐ Both

3C. ARE THERE ANY RESIDUAL CONDITIONS CAUSED BY THE BENIGN OR MALIGNANT NEOPLASM OR ITS TREATMENT *(e.g., arm swelling, nerve damage to arm)?*

☐ YES ☐ NO

(If "Yes," briefly describe the conditions and complete appropriate Questionnaire):

SECTION IV - OBJECTIVE FINDINGS AND RESIDUALS

4. DID THE SURGERY OR RADIATION TREATMENT RESULT IN THE LOSS OF 25 PERCENT OR MORE TISSUE FROM A SINGLE BREAST OR BOTH BREASTS IN COMBINATION?

☐ YES ☐ NO

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 AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO

(If "Yes," describe - brief summary):

5B. 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 appropriate dermatological DBQ)

SECTION VI - DIAGNOSTIC TESTING

NOTE - If imaging and/or diagnostic test results are in the medical record and reflect the Veteran's current condition, repeat testing is not required.

6. HAS THE VETERAN HAD IMAGING AND/OR DIAGNOSTIC TESTING AND IF SO, ARE THERE SIGNIFICANT FINDINGS AND/OR RESULTS?

☐ YES ☐ NO

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

SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S BREAST CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the Veteran's breast conditions, providing one or more examples)*

SECTION VIII - REMARKS

8. REMARKS *(If any)*

SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9A. PHYSICIAN'S SIGNATURE	9B. PHYSICIAN'S PRINTED NAME	9C. DATE SIGNED

9D. PHYSICIAN'S PHONE AND FAX NUMBERS	9E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

9F. PHYSICIAN'S MEDICAL LICENSE NUMBER AND STATE	9G. PHYSICIAN'S ADDRESS