Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE

ESOPHAGEAL CONDITIONS (Including gastroesophageal reflux disease (GERD), hiatal hernia and other esophageal 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 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 VA21-2507, 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
☐ No records were reviewed
☐ VA claims file (hard copy paper C-file
☐ VA e-folder (VBMS or Virtual VA
☐ CPRS
☐ Other (please identify other evidence reviewed):

EVIDENCE COMMENTS:

SECTION I - DIAGNOSIS

NOTE: The diagnosis of gastroesophageal reflux disease (GERD) can be made clinically by evidence of relief of typical symptoms of reflux, epigastric discomfort and/or burning, by treatment with proton pump inhibitors, histamine 2 receptor antagonists and/or antacids. If upper endoscopy was indicated or performed, the findings of erythema, ulcers and/or strictures are consistent with the diagnosis of GERD.

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN ESOPHAGEAL CONDITION?

☐ YES ☐ NO *(If "Yes," complete Item 1B)*

1B. DIAGNOSIS *(Check all that apply)*

☐ GASTROESOPHAGEAL REFLUX DISEASE (GERD) ICD CODE: ____________ DATE OF DIAGNOSIS: ____________

☐ HERNIA HIATAL ICD CODE: ____________ DATE OF DIAGNOSIS: ____________

☐ ESOPHAGUS, STRICTURE OF ICD CODE: ____________ DATE OF DIAGNOSIS: ____________

☐ ESOPHAGUS, SPASM OF *(cardiospasm)* ICD CODE: ____________ DATE OF DIAGNOSIS: ____________

☐ ESOPHAGUS, DIVERTICULUM OF, ACQUIRED ICD CODE: ____________ DATE OF DIAGNOSIS: ____________

☐ OTHER ESOPHAGEAL CONDITION(S), specify: *(such as eosinophilic esophagitis, Barrett's esophagitis, etc.)*

OTHER DIAGNOSIS #1: ____________ ICD CODE: ____________ DATE OF DIAGNOSIS: ____________

OTHER DIAGNOSIS #2: ____________ ICD CODE: ____________ DATE OF DIAGNOSIS: ____________

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO ESOPHAGEAL DISORDERS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S ESOPHAGEAL CONDITIONS *(brief summary)*:

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITION?

☐ YES ☐ NO *(If, "Yes," list only those medications used for the diagnosed condition):*

SECTION III - SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR SYMPTOMS DUE TO ANY ESOPHAGEAL CONDITIONS *(including GERD)*?

☐ YES ☐ NO

(If "Yes," check all that apply)

☐ SYMPTOMS PRODUCTIVE OF CONSIDERABLE IMPAIRMENT OF HEALTH

☐ SYMPTOMS COMBINATION PRODUCTIVE OF SEVERE IMPAIRMENT OF HEALTH

☐ PERSISTENTLY RECURRENT EPIGASTRIC DISTRESS

☐ INFREQUENT EPISODES OF EPIGASTRIC DISTRESS

☐ DYSPHAGIA

☐ PYROSIS

☐ REFLUX

☐ REGURGITATION

☐ PAIN

- ☐ Substernal
- ☐ Arm
- ☐ Shoulder

☐ SLEEP DISTURBANCE CAUSE BY ESOPHAGEAL REFLUX

If checked, indicate frequency of symptom recurrence per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of symptoms:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ MATERIAL WEIGHT LOSS

If checked, provide baseline weight: ________ and current weight: ________

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

SECTION III - SIGNS AND SYMPTOMS *(Continued)*

☐ NAUSEA

If checked, indicate frequency of episodes of nausea per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of nausea:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ VOMITING

If checked, indicate frequency of episodes of vomiting per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of vomiting:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ HEMATEMESIS

If checked, indicate frequency of episodes of hematemesis per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of hematemesis:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ MELENA WITH MODERATE ANEMIA

If checked, provide hemoglobin/hematocrit in diagnostic testing section

If checked, indicate frequency of episodes of melena per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of melena:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

SECTION IV - ESOPHAGEAL STRICTURE, SPASM AND DIVERTICULA

4. DOES THE VETERAN HAVE AN ESOPHAGEAL STRICTURE, SPASM OF ESOPHAGUS (CARDIOSPASM OR ACHALASIA), OR AN ACQUIRED DIVERTICULUM OF THE ESOPHAGUS?

☐ YES ☐ NO

If Yes, indicate severity of condition:

☐ ASYMPTOMATIC

☐ NOT AMENABLE TO DILATION

☐ AMENABLE TO DILATION

☐ MILD If checked, describe: ____________________

☐ MODERATE If checked, describe: ____________________

☐ SEVERE If checked, describe: ____________________

☐ PERMITTING LIQUIDS ONLY

☐ PERMITTING PASSAGE OF LIQUIDS ONLY, WITH MARKED IMPAIRMENT OF GENERAL HEALTH

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

5A. 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*):

SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS *(Continued)*

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 ABOVE?

☐ YES ☐ NO

IF YES, ARE ANY OF THESE SCARS PAINFUL 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 Comment section below. It is not necessary to also complete a Scars DBQ.

5C. COMMENTS, IF ANY:

SECTION VI - DIAGNOSTIC TESTING

Note: If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report.

6A. HAVE DIAGNOSTIC IMAGING STUDIES OR OTHER DIAGNOSTIC PROCEDURES BEEN PERFORMED?

☐ YES ☐ NO

If Yes, check all that apply:

☐ UPPER ENDOSCOPY

Date: ______________ Results: ______________________________

☐ UPPER GI RADIOGRAPHIC STUDIES

Date: ______________ Results: ______________________________

☐ ESOPHAGRAM *(barium swallow)*

Date: ______________ Results: ______________________________

☐ MRI

Date: ______________ Results: ______________________________

☐ CT

Date: ______________ Results: ______________________________

☐ BIOPSY, SPECIFY SITE:

Date: ______________ Results: ______________________________

☐ OTHER, SPECIFY:

Date: ______________ Results: ______________________________

6B. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO

If Yes, check all that apply:

☐ CBC Date of testing: ______________

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

☐ HELICOBACTER PYLORI Date of test: ______________ Results: ______________________________

☐ OTHER, SPECIFY: ______________ Date of test: ______________ Results: ______________________________

6C. 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

7. DO ANY OF THE VETERAN"S ESOPHAGEAL CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

If Yes, describe impact of each of the veteran's esophageal conditions, providing one ore 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 NUMBER	9E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	9F. PHYSICIAN'S ADDRESS

NOTE - VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the veteran's application.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.