Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
INFECTIOUS DISEASES (OTHER THAN HIV-RELATED ILLNESS, CHRONIC FATIGUE SYNDROME, OR TUBERCULOSIS) DISABILITY BENEFITS QUESTIONNAIRE

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

NOTE TO EXAMINER - 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.

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
☐ 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 CURRENTLY HAVE OR HAS THE VETERAN BEEN DIAGNOSED WITH AN INFECTIOUS DISEASE?

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

1B. SELECT THE VETERAN'S CONDITION *(Check all that apply):*

☐ BARTONELLOSIS	ICD code: _____	Date of diagnosis: _____
☐ BRUCELLOSIS	ICD code: _____	Date of diagnosis: _____
☐ CAMPYLOBACTER JEJUNI INFECTION	ICD code: _____	Date of diagnosis: _____
☐ COXIELLA BURNETII INFECTION (Q FEVER)	ICD code: _____	Date of diagnosis: _____
☐ HEMORRHAGIC FEVERS, INCLUDING DENGUE, YELLOW FEVER, AND OTHERS	ICD code: _____	Date of diagnosis: _____
☐ HYPERINFECTION SYNDROME OR DISSEMINATED STRONGYLOIDIASIS	ICD code: _____	Date of diagnosis: _____
☐ LEPROSY	ICD code: _____	Date of diagnosis: _____
☐ LYME DISEASE	ICD code: _____	Date of diagnosis: _____
☐ LYMPHATIC FILARIASIS, TO INCLUDE ELEPHANTIASIS	ICD code: _____	Date of diagnosis: _____
☐ MALARIA	ICD code: _____	Date of diagnosis: _____
☐ MELIOIDOSIS	ICD code: _____	Date of diagnosis: _____
☐ MILIARY TUBERCULOSIS	ICD code: _____	Date of diagnosis: _____
☐ NONTUBERCULOSIS MYCOBACTERIAL INFECTION (NTM)	ICD code: _____	Date of diagnosis: _____
☐ NONTYPHOID SALMONELLA INFECTIONS	ICD code: _____	Date of diagnosis: _____
☐ PARASITIC DISEASE OTHERWISE NOT SPECIFIED	ICD code: _____	Date of diagnosis: _____
☐ PLAGUE	ICD code: _____	Date of diagnosis: _____
☐ RELAPSING FEVER	ICD code: _____	Date of diagnosis: _____
☐ RHEUMATIC FEVER	ICD code: _____	Date of diagnosis: _____
☐ RICKETTSIAL, EHRLICHIA, AND ANAPLASMA INFECTIONS	ICD code: _____	Date of diagnosis: _____
☐ SCHISTOSOMIASIS	ICD code: _____	Date of diagnosis: _____
☐ SHIGELLA INFECTIONS	ICD code: _____	Date of diagnosis: _____
☐ SYPHILIS	ICD code: _____	Date of diagnosis: _____
☐ VIBRIOSIS (CHOLERA)	ICD code: _____	Date of diagnosis: _____
☐ VISCERAL LEISHMANIASIS	ICD code: _____	Date of diagnosis: _____
☐ WEST NILE VIRUS INFECTION	ICD code: _____	Date of diagnosis: _____
☐ OTHER *(specify):*		
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 INFECTIOUS DISEASES, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

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

SECTION III - STATUS, SYMPTOMS, AND RESIDUALS

3A. COMPLETE THE FOLLOWING SECTION(S) FOR EACH OF THE VETERAN'S INFECTIOUS DISEASE CONDITION(S):

Disease #1: _____

A. Status of disease: ☐ Active ☐ Inactive

Date of cessation of treatment for active disease: _____

If "Inactive," date condition became inactive: _____

B. Does the veteran have symptoms attributable to disease #1?

☐ Yes ☐ No

If "Yes," describe: _____

C. Does the veteran have residuals attributable to disease #1?

☐ Yes ☐ No

If "Yes," describe: _____

NOTE: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 3B C.F.R. 3.317 (d).

Disease #2: _____

A. Status of disease: ☐ Active ☐ Inactive

Date of cessation of treatment for active disease: _____

If "Inactive," date condition became inactive: _____

B. Does the veteran have symptoms attributable to disease #2?

☐ Yes ☐ No

If "Yes," describe: _____

C. Does the veteran have residuals attributable to disease #2?

☐ Yes ☐ No

If "Yes," describe: _____

NOTE: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability.Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 3B C.F.R. 3.317 (d).

Disease #3: _____

A. Status of disease: ☐ Active ☐ Inactive

Date of cessation of treatment for active disease: _____

If "Inactive," date condition became inactive: _____

B. Does the veteran have symptoms attributable to disease #3?

☐ Yes ☐ No

If "Yes," describe: _____

C. Does the veteran have residuals attributable to disease #3?

☐ Yes ☐ No

If "Yes," describe: _____

NOTE: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 3B C.F.R. 3.317 (d).

3B. IF THE VETERAN HAS ANY ADDITIONAL INFECTIOUS DISEASE CONDITIONS, LIST AND DESCRIBE BY USING THE ABOVE FORMAT:

SECTION IV - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

4A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY OF THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO *(If "Yes," describe (brief summary):*

4B. 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):

4C. COMMENTS, IF ANY:

SECTION V - DIAGNOSTIC TESTING

NOTE - VA requires diagnostic confirmation for both the initial diagnosis and any relapse or recurrence. Certain infectious diseases require specific testing methods to confirm recurrence of active infection. If testing has been performed and reflects Veteran's current condition, repeat testing is not required. (For VA purposes, **relapse** is defined as a full return of a disease or the signs and symptoms of a disease after a period of improvement and **recurrence** refers to another separate disease episode after a full recovery has been attained).

5A. FOR VISCERAL LEISHMANIASIS, MILIARY TUBERCULOSIS OR NONTUBERCULOSIS MYCOBACTERIUM INFECTION, PLEASE STATE IF THE RECURRENCE OF ACTIVE INFECTION IS CONFIRMED BY:

☐ CULTURE
☐ HISTOPATHOLOGY
☐ OTHER DIAGNOSTIC LABORATORY TESTING

Please provide type of test or procedure, date and results (brief summary):

5B. FOR MALARIA, PLEASE STATE IF THE INITIAL DIAGNOSIS OR RELAPSE IS CONFIRMED BY:

☐ IDENTIFICATION OF THE MALARIAL PARASITES IN BLOOD SMEARS

☐ IDENTIFICATION OF THE MALARIAL PARASITES IN OTHER SPECIFIC DIAGNOSTIC LABORATORY TESTS, SUCH AS ANTIGEN DETECTION, IMMUNOLOGIC (IMMUNOCHROMATOGRAPHIC) TESTS, OR MOLECULAR TESTING SUCH AS POLYMERASE CHAIN REACTION TESTS

Please provide type of test or procedure, date and results (brief summary):

5C. FOR BRUCELLOSIS, PLEASE STATE IF THE INITIAL DIAGNOSIS OR RECURRENCE OF ACTIVE INFECTION IS CONFIRMED BY:

☐ CULTURE
☐ SEROLOGIC TESTING

Please provide type of test or procedure, date and results (brief summary):

SECTION V - DIAGNOSTIC TESTING *(Continued)*

5D. FOR MELIOIDOSIS, PLEASE STATE IF THE INITIAL DIAGNOSIS AND ANY RELAPSE OR CHRONIC ACTIVITY OF INFECTION IS CONFIRMED BY:

☐ CULTURE
☐ OTHER SPECIFIC DIAGNOSTIC LABORATORY TESTS

Please provide type of test or procedure, date and results (brief summary):

5E. FOR INITIAL DIAGNOSIS, RELAPSE, OR RECURRENCE OF ALL OTHER INFECTIOUS DISEASES, PLEASE STATE THE WAY IN WHICH ACTIVE INFECTION IS CONFIRMED:

Please provide type of test or procedure, date and results (brief summary):

SECTION VI - FUNCTIONAL IMPACT

6A. DOES THE VETERAN'S INFECTIOUS DISEASE CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the Veteran's infectious disease condition(s), providing one or more examples):*

SECTION VII - REMARKS

7A. REMARKS *(If any):*

SECTION VIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

8A. PHYSICIAN'S SIGNATURE	8B. PHYSICIAN'S PRINTED NAME	8C. DATE SIGNED

8D. PHYSICIAN'S PHONE/FAX NUMBERS	8E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	8F. MEDICAL LICENSE NUMBER AND STATE

8G. PHYSICIAN'S ADDRESS