Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
PERSIAN GULF AND/OR AFGHANISTAN INFECTIOUS DISEASES (OTHER THAN 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
☐ VA electronic health record
☐ Other (please identify other evidence reviewed):
☐ No records were reviewed

EVIDENCE COMMENTS:

Note: This questionnaire is intended solely for claims based on 38 CFR 3.317(c) Presumptive service connection for infectious disease. Therefore, this questionnaire should only be completed for Veterans who have or have had one or more of the following diseases/infections of the following agents: brucellosis, Campylobacter jejuni, Coxiella burnetii (Q-fever), malaria, tuberculosis (Mycobacterium tuberculosis), nontyphoid Salmonella, Shigella, visceral leishmaniasis or West Nile virus.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN CURRENTLY HAVE OR HAS THE VETERAN BEEN DIAGNOSED WITH ANY OF THE INFECTIOUS DISEASES LISTED BELOW?

☐ YES ☐ NO

(If "Yes," complete item 1B)

1B.

☐	BRUCELLOSIS	ICD CODE:		DATE OF DIAGNOSIS:
☐	CAMPYLOBACTER JEJUNI	ICD CODE:		DATE OF DIAGNOSIS:
☐	COXIELLA BURNETII *(Q FEVER)*	ICD CODE:		DATE OF DIAGNOSIS:
☐	MALARIA	ICD CODE:		DATE OF DIAGNOSIS:
☐	NONTYPHOID SALMONELLA	ICD CODE:		DATE OF DIAGNOSIS:
☐	SHIGELLA	ICD CODE:		DATE OF DIAGNOSIS:
☐	VISCERAL LEISHMANIASIS	ICD CODE:		DATE OF DIAGNOSIS:
☐	WEST NILE VIRUS	ICD CODE:		DATE OF DIAGNOSIS:
☐	MYCOBACTERIUM TUBERCULOSIS *(TB)**	ICD CODE:		DATE OF DIAGNOSIS:

*If mycobacterium tuberculosis is the only diagnosis checked, do not complete the rest of this questionnaire. Instead, complete the Tuberculosis Disability Benefits Questionnaire. If any other disease(s) have been checked along with mycobacterium tuberculosis, complete the Tuberculosis Disability Benefits Questionnaire and ALSO complete this questionnaire for all other non-tuberculosis related diseases checked above.

SECTION II - MEDICAL HISTORY FOR DISEASE #1

2A. NAME OF DISEASE #1:

DESCRIBE HISTORY *(including onset and course)* OF THE VETERAN'S DISEASE #1:

2B. STATUS OF DISEASE #1: ☐ ACTIVE ☐ INACTIVE/TREATED AND RESOLVED

Date of cessation of treatment for active disease: _____

2C. IF INACTIVE, DATE DISEASE BECAME INACTIVE/RESOLVED: _____

2D. IF INACTIVE/RESOLVED, ARE THERE RESIDUALS DUE TO THE DISEASE?

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

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).

SECTION III - MEDICAL HISTORY FOR DISEASE #2

3A. NAME OF DISEASE #2:

DESCRIBE HISTORY *(including onset and course)* OF THE VETERAN'S DISEASE #2:

3B. STATUS OF DISEASE #2: ☐ ACTIVE ☐ INACTIVE/TREATED AND RESOLVED

Date of cessation of treatment for active disease: _____

3C. IF INACTIVE, DATE DISEASE BECAME INACTIVE/RESOLVED: _____

3D. IF INACTIVE/RESOLVED, ARE THERE RESIDUALS DUE TO THE DISEASE?

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

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).

SECTION IV - MEDICAL HISTORY FOR DISEASE #3

4A. NAME OF DISEASE #3:

DESCRIBE HISTORY *(including onset and course)* OF THE VETERAN'S DISEASE #3:

4B. STATUS OF DISEASE #3: ☐ ACTIVE ☐ INACTIVE/TREATED AND RESOLVED

Date of cessation of treatment for active disease: _____

4C. IF INACTIVE, DATE DISEASE BECAME INACTIVE/RESOLVED: _____

4D. IF INACTIVE/RESOLVED, ARE THERE RESIDUALS DUE TO THE DISEASE?

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

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).

SECTION V - ADDITIONAL PERSIAN GULF AND/OR AFGHANISTAN INFECTIOUS DISEASES

5A. IF THE VETERAN HAS HAD ANY ADDITIONAL PERSIAN GULF AND/OR AFGHANISTAN INFECTIOUS DISEASES, DESCRIBE USING ABOVE FORMAT:

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

6A. 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)):*

6B. 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):

(6C. COMMENTS, IF ANY:

SECTION VII - DIAGNOSTIC TESTING

NOTE - VA requires diagnostic confirmation for both the initial diagnosis and any relapse or recurrence. Certain Persian Gulf and/or Afghanistan 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).

7A. 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 VII - DIAGNOSTIC TESTING *(Continued)*

7B. 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)):

7C. FOR VISCERAL LEISHMANIASIS, 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)):

7D. FOR INITIAL DIAGNOSIS, RELAPSE, OR RECURRENCE OF ALL OTHER PERSIAN GULF OR AFGHANISTAN INFECTIOUS DISEASES, PLEASE STATE THE WAY IN WHICH ACTIVE INFECTION IS OR WAS CONFIRMED:

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

SECTION VIII - FUNCTIONAL IMPACT

8A. DOES THE VETERAN'S PERSIAN GULF AND/OR AFGHANISTAN INFECTIOUS DISEASE(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact of each of the Veteran's Persian Gulf and/or Afghanistan infectious diseases, providing one or more examples):*

SECTION IX - REMARKS

9A. REMARKS *(If any)*

SECTION X - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

10A. PHYSICIAN'S SIGNATURE	10B. PHYSICIAN'S PRINTED NAME	10C. DATE SIGNED

10D. PHYSICIAN'S PHONE AND FAX NUMBER	10E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	10F. MEDICAL LICENSE NUMBER AND STATE

10G. PHYSICIAN'S ADDRESS