Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
FORMER PRISONER OF WAR (POW) PROTOCOL
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

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.
Include a review of VA Form 10-0048, Former POW Medical History, which the Veteran should have completed, prior to conducting the examination.
The POW Physician Coordinator should complete summary of findings, diagnoses, and recommendations. The Coordinator should also express an opinion, with supporting reasons, concerning the relationship between the Veteran's experiences as a POW and each current medical condition. If osteoarthritis is diagnosed, it should be clarified whether this is post-traumatic osteoarthritis, and if so, whether it is related to the period of confinement.

SECTION I - SURVEY OF POTENTIAL SERVICE-CONNECTED CONDITIONS FOR FORMER POWs

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH ONE OR MORE OF THE FOLLOWING CONDITIONS?

☐ YES ☐ NO

NOTE: *For VA purposes, these conditions may be considered presumptive for service connection for former POWs if certain other regulatory requirements are met.*

1B. IF YES, CHECK ALL THAT APPLY

☐ Atherosclerotic heat disease or hypertensive vascular disease *(including hypertensive heart disease)* and their complications *(including myocardial infarction, congestive heart failure, arrhythmia).*
If checked, ALSO complete IHD or Heard Disease Questionnaire.

☐ AVITAMINOSIS
If checked, ALSO complete Nutritional Deficiencies Questionnaire.

☐ BERIBERI *(including beriberi heart disease)*
If checked, ALSO complete Nutritional Deficiencies and/or Heart Disease, if indicated.

☐ CHRONIC DYSENTERY
If checked, ALSO complete appropriate Intestines Questionnaire.

☐ CIRRHOSIS OF THE LIVER
If checked, ALSO complete Liver Conditions, including Hepatitis and Cirrhosis Questionnaire.

☐ DYSTHYMIC DISORDER *(Depressive neurosis)*
If checked, the appropriate Mental Health Questionnaire must ALSO be completed.

☐ HELMINTHIASIS
If checked, ALSO complete Questionnaires such as Nutritional Deficiencies, Infectious Diseases and/or Hematologic and Lymphatic Conditions.

☐ IRRITABLE BOWEL SYNDROME
If checked, ALSO complete Intestines (other than surgical or infectious) Questionnaire.

☐ MALNUTRITION AND/OR OTHER NUTRITIONAL DEFICIENCY *(including optic atrophy associated with malnutrition)*
If checked, ALSO complete relevant Questionnaire such as Nutritional Deficiencies *and/or Eye, if indicated.*

☐ ORGANIC RESIDUALS OF FROSTBITE *(if it is determined that the Veteran was interned in climatic conditions consistent with the occurrence of frostbite)*
If checked, ALSO complete Cold Injury Residuals Questionnaire.

☐ OSTEOPOROSIS
If checked, ALSO complete appropriate musculoskeletal Questionnaire.

☐ PELLAGRA
If checked, ALSO complete Nutritional Deficiencies Questionnaire.

☐ PEPTIC ULCER DISEASE
If checked, ALSO complete Stomach and Duodenal Conditions Questionnaire.

☐ PERIPHERAL NEUROPATHY *(except where directly related to infectious causes)*
If checked, ALSO complete Peripheral Nerves Questionnaire.

☐ POST-TRAUMATIC OSTEOARTHRITIS
If checked, ALSO complete appropriate Musculoskeletal Questionnaire.

☐ PSYCHOSIS AND/OR ANY OF THE ANXIETY STATES
If checked, the appropriate Mental Health Questionnaire must ALSO be completed.

☐ STROKE AND ITS COMPLICATIONS
If checked, ALSO complete Questionnaires such as Central Nervous System, Neuromuscular Disease, and/or Cranial Nerves Questionnaire.

SECTION II - EVIDENCE REVIEW

2. EVIDENCE REVIEWED *(check all that apply):*

☐ NOT REQUESTED

☐ NO RECORDS WERE REVIEWED

☐ VA CLAIMS FILE *(hard copy paper C-file)*

☐ VA E-FOLDER *(VBSMS or Virtual VA)*

☐ CPRS

☐ OTHER - DESCRIBE

☐ EVIDENCE COMMENTS:

SECTION III - MEDICAL HISTORY

IDENTIFY EACH AFFECTED SYSTEM/AREA *(This is the system/area/condition the Veteran is claiming or for which an exam has been requested. In particular, identify all systems/ areas conditions that may be considered presumptive for service-connection for former POWs if certain other regulatory requirements are met).*

UNDER EACH IDENTIFIED SYSTEM/ARE, SELECT THE APPROPRIATE ASSOCIATED QUESTIONNAIRES *(check all that apply)*. COMPLETE THE ASSOCIATED QUESTIONNAIRES AS PART OF THIS GENERAL MEDICAL EXAM REPORT.

☐ 3A. NO SYMPTOMS, ABNORMAL FINDINGS OR COMPLAINTS

☐ 3B. SKIN AND SCARS*:*
- ☐ SKIN DISEASES
- ☐ SCARS

☐ 3C. HEMATOLOGIC/LYMPHATIC
- ☐ HEMATOLOGIC *(including Anemia)* AND LYMPHATIC *(including Non-Hodgkin's Lymphoma)*
- ☐ HAIRY CELL & OTHER B-CELL LEUKEMIAS

☐ 3D. EYE
Note: Vision evaluations must be conducted by a specialist.

☐ 3E. HEARING LOSS, TINNITUS AND EAR
- ☐ HEARLING LOSS AND TINNITUS
- ☐ EAR CONDITIONS

Note: Audio evaluations must be conducted by a specialist.

☐ 3F. SINUS, NOSE, THROAT, DENTAL AND ORAL
- ☐ DENTAL AND ORAL CONDITIONS *(including mouth, lips and tongue)*
- ☐ LOSS OF SENSE OF SMELL AND/OR TASTE
- ☐ SINUSITIS/RHINITIS AND OTHER CONDITIONS OF THE NOSE, THROAT, LARYNX AND PHARYNX
- ☐ TEMPOROMANDIBULAR JOINT

☐ 3G. BREAST

☐ 3H. RESPIRATORY
- ☐ RESPIRATORY CONDITIONS *(other than tuberculosis and sleep apnea)*
- ☐ SLEEP APNEA
- ☐ TUBERCULOSIS

☐ 3I CARDIOVASCULAR
- ☐ ARTERY & VEIN CONDITIONS *(vascular diseases including varicose veins)*
- ☐ HYPERTENSION
- ☐ HEART DISEASE *(including arrhythmias, valvular disease, and cardiac surgery)*
- ☐ ISCHEMIC HEART DISEASE

☐ 3J. DIGESTIVE AND ABDOMINAL WALL
- ☐ ABDOMINAL, INGUINAL, AND FEMORAL HERNIAS
- ☐ ESOPHAGEAL DISORDERS *(GERD and Hiatal Hernia)*
- ☐ GALLBLADDER AND PANCREAS
- ☐ INFECTIOUS INTESTINAL CONDITIONS
- ☐ INTESTINAL CONDITIONS *(other than Surgical and Infectious)*
- ☐ INTESTINAL SURGERY
- ☐ LIVER CONDITIONS *(including hepatitis and cirrhosis)*
- ☐ PERITONEAL ADHESIONS
- ☐ RECTUM AND ANUS *(including Hemorrhoids)*
- ☐ STOMACH AND DUODENAL CONDITIONS

☐ 3K. KIDNEY AND URINARY TRACT
- ☐ KIDNEY CONDITIONS
- ☐ URINARY TRACT *(including Bladder and Urethral)* CONDITIONS

☐ 3L. REPRODUCTIVE
- ☐ GYNECOLOGICAL CONDITIONS
- ☐ MALE REPRODUCTIVE ORGANS
- ☐ PROSTATE CANCER

SECTION III - MEDICAL HISTORY *(Continued)*

☐ 3M. MUSCULOSKELETAL

SPINE

- ☐ BACK *(Thoracolumbar Spine)* CONDITIONS
- ☐ NECK *(Cervical Spine)* CONDITIONS

JOINTS AND EXTREMETIES

- ☐ ANKLE
- ☐ ELBOW AND FOREARM
- ☐ HANDS AND FINGERS
- ☐ HIP AND THIGH
- ☐ KNEE AND LOWER LEG
- ☐ SHOULDER AND ARM
- ☐ WRIST

FEET

- ☐ FLATFEET
- ☐ FOOT *(other than Flatfeet)*

MISCELLANEOUS MUSCULOSKELETAL

- ☐ AMPUTATIONS
- ☐ ARTHRITIS *(non-degenerative arthritis, including inflammatory, autoimmune, crystalline and infectious arthritis, and dysbaric osteonecrosis)*
- ☐ BONE CONDITIONS, MISCELLANOUS, INCLUDING OSTEOMYELITIS
- ☐ FIBROMYALGIA
- ☐ MUSCLE INJURIES

☐ OSTEOPOROSIS/OSTEOPENIA

IF CHECKED, PROVIDE DEXASCAN RESULTS: DATE OF SCAN:

IF CHECKED, ARE THERE JOINT MANIFESTATIONS OF OSTEOPOROSIS/OSTEOPENIA *(Osteoporosis may or may not present as spine or joint disease)*?

☐ Yes ☐ No IF YES, COMPLETE APPROPRIATE QUESTIONNAIRE FOR AFFECTED JOINT(S)/SPINE.

☐ 3N. ENDOCRINE

- ☐ DIABETES MELITUS
- ☐ ENDOCRINE DISEASES *(other than Thyroid, Parathyroid, or Diabetes Mellitus)*
- ☐ THYROID AND PARATHYROID

☐ 3O. NEUROLOGIC

- ☐ AMYOTROPHIC LATERAL SCLEROSIS (ALS)
- ☐ CRANIAL NERVES DISEASES
- ☐ DIABETIC SENSORY-MOTOR PERIPHERAL NEUROPATHY
- ☐ DISEASE OF THE CENTRAL NERVOUSE SYSTEM
- ☐ FIBROMYALGIA
- ☐ HEADACHES *(including Migraine Headaches)*
- ☐ NARCOLEPSY
- ☐ MULTIPLE SCLEROSIS
- ☐ PARKINSON'S DISEASE
- ☐ PERIPHERAL NERVES
- ☐ SEIZUER DISORDER *(Epilepsy)*
- ☐ TRAUMATIC BRAIN INJURY *(Initial or Review)*

(The Initial and Review TBI Questionnaire may only be completed by a VA clinician who has completed the TBI CP certification. The initial diagnosis of TBI must be made by a specialist, but a certified generalist can complete the disability exam for TBI.)

☐ 3P. PSYCHIATRIC

- ☐ EATING DISORDERS
- ☐ MENTAL DISORDERS *(other than PTSD)*
- ☐ PTSD *(Initial or Review)*

Note: Mental disorder evaluations must be conducted by a specialist.

SECTION III - MEDICAL HISTORY *(Continued)*

☐ 3Q. INFECTIOUS DISEASE, IMMUNE DISORDER OR NUTRITIONAL DEFICIENCY

- ☐ CHRONIC FATIGUE SYNDROME
- ☐ HIV AND RELATED ILLNESSES
- ☐ INFECTIOUS DISEASES
- ☐ NUTRITIONAL DEFICIENCIES
- ☐ PERSIAN GULF AND AFGHANISTAN INFECTIOUS DISEASES
- ☐ SYSTEMIC LUPUS ERYTHEMATOSUS OR OTHER IMMUNE DISORDERS
- ☐ TUBERCULOSIS

☐ 3R. MISCELLANEOUS

- ☐ COLD INJURY RESIDUALS
- ☐ GULF WAR GENERAL MEDICAL EXAMINATION

SECTION IV - DIAGNOSES NOT ADDRESSED ON ABOVE QUESTIONNAIRES

LIST ADDITIONAL DIAGNOSES THAT ARE NOT ADDRESSED ON THE ABOVE QUESTIONNAIRES, IF ANY:

ADDITIONAL DIAGNOSIS #1 _____ ICD Code: _____ Date of diagnosis: _____

ADDITIONAL DIAGNOSIS #2 _____ ICD Code: _____ Date of diagnosis: _____

ADDITIONAL DIAGNOSIS #3 _____ ICD Code: _____ Date of diagnosis: _____

IF THERE ARE ADDITIONAL DIAGNOSES, LIST USING ABOVE FORMAT:

SECTION V - PHYSICAL EXAM

☐ NORMAL PE

☐ NORMAL PE, EXCEPT AS NOTED ON ADDITIONAL QUESTIONNAIRES INCLUDED AS PART OF THIS REPORT

☐ OTHER, DESCRIBE

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

6A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

IF YES, DESCRIBE (*brief summary*):

6B. 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.

6C. COMMENTS, IF ANY:

SECTION VII - FUNCTIONAL IMPACT

7. DO ANY OF THE VETERAN'S CONDITIONS THAT ARE ETIOLOGICALLY RELATED TO THE PRIOSONER OF WAR EXPERIENCE IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

(If "Yes," describe impact of each of the Veteran's prisoner of war related conditions, providing one or more examples for only those conditions that are not described on other Questionnaires)):

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/FAX NUMBERS	9E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	9F. PHYSICIAN'S ADDRESS

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

IMPORTANT - Physician please fax the completed form to _____

(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at **www.benefits.va.gov/disabilityexams** or obtained by calling 1-800-827-1000.

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, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. 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 low 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 a 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.