



NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

**NOTE TO EXAMINER** - The Veteran/Claimant 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 QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA21-2507, C&P EXAMINATION REQUEST?

YES  NO

How was the examination completed? (check all that apply)

- In-person examination
- Records reviewed
- Examination via approved video telehealth
- Other, please specify in comments box:

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

**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**

1. DOES THE VETERAN HAVE A CURRENT SKIN CONDITION?

YES  NO

For Burn Conditions, the SCARS/DISFIGUREMENT DISABILITY BENEFITS QUESTIONNAIRE must be completed.

IF YES, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO SKIN CONDITIONS. INDICATE THE CATEGORY OF SKIN CONDITION, AND THEN PROVIDE SPECIFIC DIAGNOSIS IN THAT CATEGORY (*check all that apply*):

- Dermatitis or eczema  
Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Tumors and neoplasms of the skin, including malignant melanoma  
Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Dermatophytosis (ringworm: of body, tinea corporis; of head, tinea capitis; of feet, tinea pedis; of beard area, tinea barbae; of nails, tinea unguium (onychomycosis); of inguinal area (jock itch), tinea cruris; tinea versicolor)  
Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Acne  
ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Psoriasis  
ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Infectious skin conditions not listed elsewhere (including bacterial, fungal, viral, treponemal and parasitic skin conditions)  
Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Chronic Urticaria  
ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Alopecia  
Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Keratinization skin disorders (including ichthyoses, Darier's disease, and palmoplantar keratoderma)  
Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Erythroderma (exfoliative dermatitis)  
ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Papulosquamous skin disorders not listed elsewhere (including lichen planus, large or small plaque parapsoriasis, pityriasis lichenoides et varioliformis acuta (PLEVA), lymphomatoid papulosus, mycosis fungoides and pityriasis rubra pilaris (PRP))  
Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Hyperhidrosis  
ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Vitiligo  
ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Bullous disorders (including pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, dermatitis herpetiformis, epidermolysis bullosa acquisita, benign chronic familial pemphigus (Hailey-Hailey), and porphyria cutanea tarda)  
Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Cutaneous manifestations of collagen-vascular diseases not listed elsewhere (including scleroderma, calcinosis cutis, and dermatomyositis)  
Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Chloracne  
ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Discoid lupus or subacute cutaneous lupus erythematosus  
ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Erythema multiforme (toxic epidermal necrolysis)  
ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Primary cutaneous vasculitis  
ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Other skin condition  
Other diagnosis #1: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_  
Other diagnosis #2: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_  
Other diagnosis #3: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

**SECTION II - MEDICAL HISTORY**

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

2B. RESOLVED SKIN CONDITIONS - DID THE VETERAN PREVIOUSLY HAVE A SKIN CONDITION THAT IS NOW COMPLETELY RESOLVED AND NO LONGER REQUIRES TREATMENT OF ANY TYPE? (*brief summary*):

2C. COMMENTS, IF ANY:

SECTION III - TREATMENT

3A. HAS THE VETERAN BEEN TREATED WITH MEDICATION IN THE PAST 12 MONTHS FOR ANY SKIN CONDITION?

YES  NO

IF YES, CHECK ALL THAT APPLY:

Corticosteroids or other immunosuppressive medications

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration):  Oral  Injection  Intranasal  Suppository  Topical  Other: \_\_\_\_\_

(Total duration of medication use in past 12 months):

<6 weeks  6 weeks or more, but not constant  Constant/near-constant

Antihistamines

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration):  Oral  Injection  Intranasal  Suppository  Topical  Other: \_\_\_\_\_

(Total duration of medication use in past 12 months):

<6 weeks  6 weeks or more, but not constant  Constant/near-constant

Retinoids

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration):  Oral  Injection  Intranasal  Suppository  Topical  Other: \_\_\_\_\_

(Total duration of medication use in past 12 months):

<6 weeks  6 weeks or more, but not constant  Constant/near-constant

Sympathomimetics

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration):  Oral  Injection  Intranasal  Suppository  Topical  Other: \_\_\_\_\_

(Total duration of medication use in past 12 months):

<6 weeks  6 weeks or more, but not constant  Constant/near-constant

Biologics

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration):  Oral  Injection  Intranasal  Suppository  Topical  Other: \_\_\_\_\_

(Total duration of medication use in past 12 months):

<6 weeks  6 weeks or more, but not constant  Constant/near-constant

Other medication

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration):  Oral  Injection  Intranasal  Suppository  Topical  Other: \_\_\_\_\_

(Total duration of medication use in past 12 months):

<6 weeks  6 weeks or more, but not constant  Constant/near-constant

Other medication

(If checked, list medication(s):

(Specify condition medication used for):

(Specify the route of administration):  Oral  Injection  Intranasal  Suppository  Topical  Other: \_\_\_\_\_

(Total duration of medication use in past 12 months):

<6 weeks  6 weeks or more, but not constant  Constant/near-constant

NOTE: If a medication is used for more than one condition, provide names of all conditions, name of medication used for each condition, and frequency of use for each condition:

**SECTION III - TREATMENT (Continued)**

3B. HAS THE VETERAN HAD ANY TREATMENTS OR PROCEDURES OTHER THAN SYSTEMIC OR TOPICAL MEDICATIONS IN THE PAST 12 MONTHS FOR ANY SKIN CONDITION?

YES  NO

IF YES, CHECK ALL THAT APPLY:

**Phototherapy such as ultraviolet-B light (UVB) treatment**

(If checked, date of most recent treatment): \_\_\_\_\_

(Specify condition treated): \_\_\_\_\_

(Total duration of medication use in past 12 months): \_\_\_\_\_

<6 weeks  6 weeks or more, but not constant  Constant/near-constant

**Photochemotherapy (to include PUVA (psoralen with long wave ultraviolet A light)) treatment**

(If checked, date of most recent treatment): \_\_\_\_\_

(Specify condition treated): \_\_\_\_\_

(Total duration of medication use in past 12 months): \_\_\_\_\_

<6 weeks  6 weeks or more, but not constant  Constant/near-constant

**Electron beam therapy**

(If checked, date of most recent treatment): \_\_\_\_\_

(Specify condition treated): \_\_\_\_\_

(Total duration of medication use in past 12 months): \_\_\_\_\_

<6 weeks  6 weeks or more, but not constant  Constant/near-constant

**Intensive light therapy**

(If checked, date of most recent treatment): \_\_\_\_\_

(Specify condition treated): \_\_\_\_\_

(Total duration of medication use in past 12 months): \_\_\_\_\_

<6 weeks  6 weeks or more, but not constant  Constant/near-constant

**Other treatment (Specify treatment):** \_\_\_\_\_

(If checked, date of most recent treatment): \_\_\_\_\_

(Specify condition treated): \_\_\_\_\_

(Total duration of medication use in past 12 months): \_\_\_\_\_

<6 weeks  6 weeks or more, but not constant  Constant/near-constant

**Other treatment (Specify treatment):** \_\_\_\_\_

(If checked, date of most recent treatment): \_\_\_\_\_

(Specify condition treated): \_\_\_\_\_

(Total duration of medication use in past 12 months): \_\_\_\_\_

<6 weeks  6 weeks or more, but not constant  Constant/near-constant

**SECTION IV - PHYSICAL EXAM**

4A. INDICATE THE VETERAN'S VISIBLE CHARACTERISTIC LESIONS DUE TO THE SKIN CONDITION(S); INDICATE THE APPROXIMATE TOTAL BODY AREA AND APPROXIMATE TOTAL **EXPOSED** BODY AREA (face, neck and hands) AFFECTED ON CURRENT EXAMINATION (check all that apply):

<input type="checkbox"/> Dermatitis	Total body area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
	EXPOSED area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
<input type="checkbox"/> Eczema	Total body area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
	EXPOSED area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
<input type="checkbox"/> Dermatophytosis	Total body area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
	EXPOSED area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
<input type="checkbox"/> Bullous disorders	Total body area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
	EXPOSED area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
<input type="checkbox"/> Cutaneous manifestations of collagen vascular disorders not listed elsewhere	Total body area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
	EXPOSED area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
<input type="checkbox"/> Psoriasis	Total body area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
	EXPOSED area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%

**SECTION IV - PHYSICAL EXAM (Continued)**

<input type="checkbox"/> Infections of the skin not listed elsewhere	Total body area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
	EXPOSED area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
<input type="checkbox"/> Papulosquamous disorders not listed elsewhere	Total body area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
	EXPOSED area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
<input type="checkbox"/> Diseases of keratinization	Total body area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
	EXPOSED area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
<input type="checkbox"/> Discoid lupus erythematosus	Total body area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
	EXPOSED area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
<input type="checkbox"/> Other	Total body area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
	Indicate diagnosis:	EXPOSED area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%
<input type="checkbox"/> Other	Total body area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
	Indicate diagnosis:	EXPOSED area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%
<input type="checkbox"/> Other	Total body area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%	<input type="checkbox"/> >40%
	Indicate diagnosis:	EXPOSED area	<input type="checkbox"/> None	<input type="checkbox"/> <5%	<input type="checkbox"/> 5% to <20%	<input type="checkbox"/> 20% to 40%

Does the Veteran have a skin condition currently without any visible characteristic lesions at the time of the examination?

YES     NO

4B. FOR EACH SKIN CONDITION CHECKED IN ITEM 4A, GIVE SPECIFIC DIAGNOSIS AND DESCRIBE APPEARANCE AND LOCATION:

**SECTION V - SPECIFIC SKIN CONDITIONS**

5. INDICATE THE VETERAN'S SPECIFIC SKIN CONDITIONS AND COMPLETE ALL APPLICABLE SUBSEQUENT QUESTIONS *(check all that apply)*:

Acne  
*(If checked, indicate severity and location (check all that apply)):*  
 Superficial acne (comedones, papules, pustules) of any extent  
 Deep acne (deep inflamed nodules and pus-filled cysts)  
      Affects less than 40% of face and neck  
      Affects 40% or more of face and neck  
      Affects body areas other than face and neck

Chloracne  
*(If checked, indicate severity and location (check all that apply)):*  
 Superficial acne (comedones, papules, pustules) of any extent  
 Deep acne (deep inflamed nodules and pus-filled cysts)  
      Affects less than 40% of face and neck  
      Affects 40% or more of face and neck  
      Affects intertriginous areas (axilla of the arm, anogenital region, skin folds of the breasts, or between digits)  
      Affects non-intertriginous body areas other than face and neck

Vitiligo  
*(If checked, indicate areas affected by vitiligo):*  
 Exposed areas affected  
 No exposed areas affected

Scarring alopecia  
*(If checked, indicate percent of scalp affected):*  
 <20%     20% to 40%     >40%

Alopecia areata  
*(If checked, indicate amount of hair loss):*  
 Hair loss limited to scalp and face     Loss of all body hair     Other, describe: \_\_\_\_\_

**SECTION V - SPECIFIC SKIN CONDITIONS (Continued)**

**Hyperhidrosis**

*(If checked, indicate severity):*

- Able to handle paper or tools after treatment       Unresponsive to treatment; unable to handle paper or tools

**Urticaria, chronic**

Has the Veteran ever had a break in treatment?       YES       NO

If "Yes," did he/she experience symptoms at least twice a week for six weeks or more?       YES       NO

Indicate the type of treatment the Veteran is currently receiving:

- First line treatment
- Antihistamines
  - Other:
- Second line treatment
- Corticosteroids
  - Sympathomimetics
  - Leukotriene inhibitors
  - Neutrophil inhibitors
  - Thyroid hormone
  - Other:
- Third line treatment
- Plasmapheresis
  - Immunotherapy
  - Immunosuppressives
  - Other:

**Vasculitis, primary cutaneous**

Frequency of documented, vasculitis episodes occurring over the past 12 months:

- None
- 1 to 3
- 4 or more

Has the Veteran required the use of systemic immunosuppressive therapy over the past 12 months?       YES       NO

If "Yes," check the applicable frequency:

- Intermittent
- Continuous

Has the Veteran continued to have vasculitis episodes despite continuous systemic immunosuppressive therapy over the past 12 months?       YES       NO

**Erythroderma (exfoliative dermatitis)**

*(If checked, is there erythroderma/exfoliative dermatitis with any extent of involvement of the skin?)*

- YES       NO

*(If yes, check all that apply):*

- Generalized involvement of the skin with systemic manifestations (such as fever, weight loss, or hypoproteinemia)
- Generalized involvement of the skin without systemic manifestations
- No current treatment due to a documented history of treatment failure with 2 or more treatment regimens
- No current treatment due to a documented history of treatment failure with 1 treatment regimen

**NOTE:** Treatment failure is defined as either disease progression, or less than a 25 percent reduction in the extent and severity of disease after four weeks of prescribed therapy, as documented by medical records.

**Erythema multiforme; toxic epidermal necrolysis**

*(If checked, indicate severity and frequency):*

- Mucosal involvement
- Impairing mastication       Not impairing mastication
  - Without recurrent episodes       One to three episodes over the past 12-month period
  - Four or more episodes over the past 12-month period

**SECTION V - SPECIFIC SKIN CONDITIONS (Continued)**

- Palmar involvement  
 Impairing use of hands       Not impairing use of hands  
 Without recurrent episodes       One to three episodes over the past 12-month period  
 Four or more episodes over the past 12-month period

- Plantar involvement  
 Impairing ambulation       Not impairing ambulation  
 Without recurrent episodes       One to three episodes over the past 12-month period  
 Four or more episodes over the past 12-month period

Indicate the type of treatment the Veteran is currently receiving:

- Ongoing immunosuppressive therapy  
 Intermittent systemic therapy (immunosuppressives, antihistamines, or sympathomimetics)  
 Continuous systemic medication for control

Veteran does not have any of the specific skin conditions listed above.

**SECTION VI - TUMORS AND NEOPLASMS**

6A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION?

YES     NO    (If "Yes," complete items 6B through 6D)

6B. IS THE NEOPLASM:

- BENIGN       MALIGNANT (If malignant, indicate status of disease):  
 ACTIVE

- SURGERY (if checked describe): \_\_\_\_\_  
 ANTINEOPLASTIC CHEMOTHERAPY  
 RADIATION  
 X-RAY TREATMENT  
 WATCHFUL WAITING  
 OTHER (if checked describe): \_\_\_\_\_

Anticipated date of final treatment (surgical, antineoplastic chemotherapy, radiation, X-ray treatment, or other): \_\_\_\_\_

- REMISSION  
 SURGERY (if checked describe): \_\_\_\_\_  
 ANTINEOPLASTIC CHEMOTHERAPY  
 RADIATION  
 X-RAY TREATMENT  
 WATCHFUL WAITING  
 OTHER (if checked describe): \_\_\_\_\_

Date treatment was completed or date of anticipated final treatment (surgical, antineoplastic chemotherapy, radiation, X-ray treatment, or other): \_\_\_\_\_

6C. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (INCLUDING METASTASES) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT ABOVE?

YES     NO

(If "Yes," list residual conditions and complications - brief summary): \_\_\_\_\_

6D. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION, DESCRIBE USING THE ABOVE FORMAT:

**SECTION VII - SCARRING AND DISFIGUREMENT**

7. DO ANY OF THE VETERAN'S SKIN CONDITIONS CAUSE SCARRING (REGARDLESS OF LOCATION), OR DISFIGUREMENT OF THE HEAD, FACE OR NECK?

YES  NO (If "Yes," complete the Scars/Disfigurement DBQ).

**SECTION VIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS**

8A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES  NO (If "Yes," describe and complete the appropriate DBQ):

8B. COMMENTS, IF ANY:

**SECTION IX - FUNCTIONAL IMPACT**

9. DO ANY OF THE VETERAN'S SKIN CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

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

**SECTION X - REMARKS**

10. REMARKS (If any):

**SECTION XI - PHYSICIAN'S CERTIFICATION AND SIGNATURE**

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

11A. PHYSICIAN'S SIGNATURE

11B. PHYSICIAN'S PRINTED NAME

11C. DATE SIGNED

11D. PHYSICIAN'S PHONE AND FAX NUMBER

11E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

11F. MEDICAL LICENSE NUMBER AND STATE

11G. PHYSICIAN'S ADDRESS