Department of Veterans Affairs

ESOPHAGEAL CONDITIONS (Including gastroesophageal reflux disease (GERD), hiatal hernia and other esophageal disorders) DISABILITY BENEFITS QUESTIONNAIRE

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

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.

Note - 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. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the veteran's application. VA reserves the right to confirm the authenticity of ALL questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

☐ Veteran/Claimant

☐ Other: please describe

Are you a VA Healthcare provider? ◯ Yes ◯ No

Is the Veteran regularly seen as a patient in your clinic? ◯ Yes ◯ No

Was the Veteran examined in person? ◯ Yes ◯ No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

◯ No records were reviewed

◯ Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

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

SECTION III - SIGNS AND SYMPTOMS *(Continued)*

☐ 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)

☐ 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 - TUMORS AND NEOPLASMS

5A. Does the Veteran currently have, or has had, a benign or malignant neoplasm or metastases related to any condition in the diagnosis section?

◯ Yes ◯ No If yes, complete the following section.

5B. Is the neoplasm

◯ Benign
◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

◯ Primary ◯ Secondary (metastatic) (if secondary, indicate the primary site, if known): _____

SECTION V - TUMORS AND NEOPLASMS *(Continued)*

5C. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?

◯ Yes ◯ No; watchful waiting

If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

☐ Treatment completed

☐ Surgery
If checked, describe: _____
Date(s) of surgery: _____

☐ Radiation therapy
Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

☐ Antineoplastic chemotherapy
Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

☐ Other therapeutic procedure
If checked, describe procedure: _____
Date of most recent procedure: _____

☐ Other therapeutic treatment
If checked, describe treatment: _____
Date of completion of treatment or anticipated date of completion: _____

5D. Does the Veteran currently have any residuals 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 residuals or complications (brief summary), and also complete the appropriate questionnaire:

5E. 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 VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

6A. 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 VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS *(Continued)*

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 - DIAGNOSTIC TESTING

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

7A. 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: _____

7B. 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: _____

7C. 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 VIII - FUNCTIONAL IMPACT

8. 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 IX - REMARKS

9. REMARKS *(If any)*

SECTION X - EXAMINER'S CERTIFICATION AND SIGNATURE

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

10A. Examiner's signature:

10B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

10C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

10D. Date Signed:

10E. Examiner's phone/fax numbers:

10F. National Provider Identifier (NPI) number:

10G. Medical license number and state:

10H. Examiner'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.