Department of Veterans Affairs

STOMACH AND DUODENAL CONDITIONS (NOT INCLUDING GERD OR 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

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER HAD ANY STOMACH OR DUODENUM CONDITIONS?

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

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

	Condition	ICD code	Date of diagnosis
☐	GASTRIC ULCER	ICD code:	Date of diagnosis:
☐	DUODENAL ULCER	ICD code:	Date of diagnosis:
☐	STENOSIS OF THE STOMACH	ICD code:	Date of diagnosis:
☐	MARGINAL (GASTROJEJUNAL) ULCER	ICD code:	Date of diagnosis:
☐	HYPERTROPHIC GASTRITIS	ICD code:	Date of diagnosis:
☐	POSTGASTRECTOMY SYNDROME	ICD code:	Date of diagnosis:
☐	STATUS POST VAGOTOMY WITH PYLOROPLASTY	ICD code:	Date of diagnosis:
☐	GASTROENTEROSTOMY	ICD code:	Date of diagnosis:
☐	PERITONEAL ADHESIONS FOLLOWING INJURY OR SURGERY OF THE STOMACH	ICD code:	Date of diagnosis:
☐	HELICOBACTER PYLORI	ICD code:	Date of diagnosis:

☐ OTHER STOMACH OR DUODENAL CONDITIONS

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 STOMACH OR DUODENUM CONDITIONS, LIST USING ABOVE FORMAT:

NOTE: The diagnosis of gastric or duodenal ulcer or stenosis can be made by upper gastrointestinal imaging series or endoscopy. The diagnosis of gastritis requires endoscopic confirmation. If testing is of record and is consistent with Veteran's current condition, repeat testing is not required.

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S STOMACH OR DUODENUM 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 STOMACH OR DUODENUM CONDITIONS?

☐ YES ☐ NO

IF YES, *(check all that apply)*:

☐ Recurring episodes of symptoms that are not severe
If checked, indicate frequency of episodes 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

☐ Recurring episodes of severe symptoms
If checked, indicate frequency of episodes 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

☐ Abdominal Pain
If checked, indicate severity and frequency *(check all that apply)*:
☐ Occurs less than monthly
☐ Occurs at least monthly
☐ Pronounced
☐ Periodic
☐ Continuous
☐ Relieved by standard ulcer therapy
☐ Only partially relieved by standard ulcer therapy
☐ Unrelieved by standard ulcer therapy

☐ Anemia
If checked, provide hemoglobin/hematocrit in diagnostic testing section.

☐ 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 severity:
☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic
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 severity:
☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic
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 severity:
☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic
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
If checked, indicate severity:
☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic
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 - INCAPACITATING EPISODES

4. DOES THE VETERAN HAVE INCAPACITATING EPISODES DUE TO SIGNS OR SYMPTOMS OF ANY STOMACH OR DUODENUM CONDITION?

☐ YES ☐ NO

IF YES, DESCRIBE INCAPACITATING EPISODES: ____________________

Indicate frequency of incapacitating episodes per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Indicate average duration of incapacitating episodes:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

SECTION V - OTHER CONDITIONS

5. DOES THE VETERAN HAVE ANY OF THE FOLLOWING CONDITIONS?

☐ YES ☐ NO

IF YES, INDICATE CONDITIONS AND COMPLETE APPROPRIATE SECTIONS *(check all that apply)*:

☐ Hypertrophic gastritis

If checked, indicate severity:

- ☐ No symptoms or findings
- ☐ Chronic, with small nodular lesions, and symptoms
- ☐ Chronic, with multiple small eroded or ulcerated areas, and symptoms
- ☐ Chronic, with severe hemorrhages, or large ulcerated or eroded areas

NOTE: If atrophic gastritis is present, state the underlying cause: ____________________

☐ Postgastrectomy syndrome

If checked, indicate severity:

- ☐ No symptoms or findings
- ☐ Mild; infrequent episodes of epigastric distress with characteristic mild circulatory symptoms or continuous mild manifestations
- ☐ Moderate; less frequent episodes of epigastric disorders with characteristic mild circulatory symptoms after meals but with diarrhea and weight loss
- ☐ Severe; associated with nausea, sweating, circulatory disturbance after meals, diarrhea, hypoglycemic symptoms, and weight loss with malnutrition and anemia

☐ Vagotomy with pyloroplasty or gastroenterostomy

If checked, indicate the severity of residuals following vagotomy with pyloroplasty or gastroenterostomy:

- ☐ No symptoms or findings
- ☐ Recurrent ulcer with incomplete vagotomy
- ☐ Symptoms and confirmed diagnosis of alkaline gastritis, or of confirmed persisting diarrhea
- ☐ Demonstrably confirmative postoperative complications of stricture or continuing gastric retention

☐ Peritoneal adhesions following an injury or surgical procedure of the stomach or duodenum

If checked, ALSO complete the Peritoneal Adhesions Questionnaire.

SECTION VI - TUMORS AND NEOPLASMS

6A. 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.

6B. Is the neoplasm

◯ Benign

◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

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

6C. 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

SECTION VI - TUMORS AND NEOPLASMS (continued)

☐ 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: ______

6D. 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:

6E. 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 - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

7A. 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 VII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS (continued)

7B. 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.

7C. COMMENTS, IF ANY:

SECTION VIII - DIAGNOSTIC TESTING

NOTE: If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report.
The diagnosis of gastric or duodenal ulcer or stenosis can be made by upper gastrointestinal imaging series or endoscopy.

8A. 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: ________
☐ MRI Date: ________ Results: ________
☐ CT Date: ________ Results: ________
☐ Biopsy, specify site: ________ Date: ________ Results: ________
☐ Other, specify: ________ Date: ________ Results: ________

8B. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐ CBC Date of test: ________

Hemoglobin: ________ Hematocrit: ________ White blood cell count: ________ Platelets: ________

☐ Helicobacter pylori Date of test: ________ Results: ________

☐ Other, specify: ________ Date of test: ________ Results: ________

8C. 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 IX - FUNCTIONAL IMPACT

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

☐ YES ☐ NO

IF YES, DESCRIBE IMPACT OF EACH OF THE VETERAN'S STOMACH OR DUODENUM CONDITIONS, PROVIDING ONE OR MORE EXAMPLES:

SECTION X - REMARKS

10. REMARKS *(If any)*

SECTION XI - EXAMINER'S CERTIFICATION AND SIGNATURE

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

11A. Examiner's signature:

11B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

11C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

11D. Date Signed:

11E. Examiner's phone/fax numbers:

11F. National Provider Identifier (NPI) number:

11G. Medical license number and state:

11H. 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, 58VA21/22/28, 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 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.