

Department of Veterans Affairs **ARTERY AND VEIN CONDITIONS (VASCULAR DISEASES INCLUDING VARICOSE VEINS) 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 ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
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NOTE TO PHYSICIAN - 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.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN HAVE VASCULAR DISEASE(S) (ARTERIAL OR VENOUS)?
 YES NO *(If "No," complete Item 1B)*

1B. PROVIDE THE RATIONALE/REASON (e.g., veteran does not currently have any known vascular condition(s))

Note: Provide only diagnoses that pertain to vascular condition(s):

1C. DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
1D. DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
1E. DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1F. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO VASCULAR DISEASES, LIST USING ABOVE FORMAT

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE CAUSE/ONSET OF THE VETERAN'S CURRENT VASCULAR CONDITION(S) *(Provide a brief summary)*

2B. TYPE OF VASCULAR DISEASE CONDITION *(Check all that apply and then complete the corresponding Section(s) III-VIII)*

Section III: Varicose veins and/or post-phlebitic syndrome
 Section IV: Peripheral vascular disease, aneurysm of any large artery *(other than aorta)*, arteriosclerosis obliterans or thrombo-angitis obliterans *(Buerger's Disease)*
 Section V: Aortic aneurysm
 Section VI: Aneurysm of a small artery
 Section VII: Raynaud's syndrome
 Section VIII: Arteriovenous (AV) fistula, angioneurotic edema or erythromelalgia

SECTION III - VARICOSE VEINS AND/OR POST- PHLEBITIC SYNDROME

3A. DOES THE VETERAN HAVE VARICOSE VEINS OR POST-PHLEBITIC SYNDROME OF ANY ETIOLOGY?
 YES NO *(If "Yes," complete Items 3B and 3C)*

3B. CHECK ALL SYMPTOMS THAT APPLY AND INDICATE EXTREMITY AFFECTED:

<input type="checkbox"/> Asymptomatic palpable varicose veins	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Asymptomatic visible varicose veins	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Aching and fatigue in leg after prolonged standing or walking	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Symptoms relieved by elevation of extremity	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Symptoms relieved by compression hosiery	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both

3C. CHECK ALL SYMPTOMS THAT APPLY AND INDICATE EXTREMITY AFFECTED:

<input type="checkbox"/> Incipient stasis pigmentation or eczema	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Persistent stasis pigmentation or eczema	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Intermittent ulceration	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Intermittent edema of extremity	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Persistent edema that is incompletely relieved by elevation of extremity	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Persistent edema	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Persistent subcutaneous induration	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Massive board-like edema	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Constant pain at rest	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both

SECTION IV - PERIPHERAL VASCULAR DISEASE, ANEURYSM OF ANY LARGE ARTERY (OTHER THAN AORTA) ARTERIOSCLEROSIS OBLITERANS OR THROMBO-ANGIITIS OBLITERANS (BUERGER'S DISEASE)

4A. HAS THE VETERAN BEEN DIAGNOSED WITH PERIPHERAL VASCULAR DISEASE, ANEURYSM OF ANY LARGE ARTERY (OTHER THAN AORTA) ARTERIOSCLEROSIS OBLITERANS OR THROMBO-ANGIITIS OBLITERANS (BUERGER'S DISEASE)?

YES NO (If "Yes," complete Items 4B through 4D)

4B. HAS THE VETERAN UNDERGONE SURGERY FOR ANY OF THESE LISTED CONDITIONS?

YES NO (If "Yes," list type of surgery: _____ Date of surgery: _____)

4C. HAS THE VETERAN UNDERGONE ANY PROCEDURE (OTHER THAN SURGERY) FOR REVASCULARIZATION?

YES NO (If "Yes," list type of procedure: _____ Date of procedure: _____)

4D. INDICATE SEVERITY OF CURRENT SIGNS AND SYMPTOMS AND INDICATE EXTREMITY AFFECTED: (Check all that apply)

- | | | | |
|--|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Claudication on walking more than 100 yards | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Claudication on walking less than 25 yards on a level grade at 2 miles per hour | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Persistent coldness of the extremity | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Diminished peripheral pulses | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Ischemic limb pain at rest | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Trophic changes (thin skin, absence of hair, dystrophic nails) | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> 1 or more deep ischemic ulcers | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |

SECTION V - AORTIC ANEURYSM

5A. HAS THE VETERAN EVER BEEN DIAGNOSED WITH AN AORTIC ANEURYSM?

YES NO (If "Yes," complete Item 5B)

5B. HAS THE VETERAN HAD A SURGICAL PROCEDURE FOR AN AORTIC ANEURYSM?

YES NO (If "Yes," indicate type of surgery: _____ Date of surgery: _____)

5C. DOES THE VETERAN CURRENTLY HAVE AN AORTIC ANEURYSM?

- YES NO (If "Yes," indicate severity)
- 5 centimeters or larger in diameter
 - Symptomatic
 - Precludes exertion

6. REMARKS (If any)

SECTION VII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

7A. PHYSICIAN'S SIGNATURE		7B. PHYSICIAN'S PRINTED NAME	7C. DATE SIGNED
7D. PHYSICIAN'S PHONE NUMBER		7E. PHYSICIAN'S MEDICAL LICENSE NUMBER	7F. PHYSICIAN'S ADDRESS

NOTE - VA may request 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.vba.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, 58/VA21/22/28, 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 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 30 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.