



Department of Veterans Affairs

**STOMACH AND DUODENAL CONDITIONS (NOT INCLUDING GERD OR ESOPHAGEAL DISORDERS) 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 THIS 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 NOW HAVE OR HAS HE OR SHE HAD ANY STOMACH OR DUODENUM CONDITION?

YES  NO (If "No," complete Item 1B) (If "Yes," complete Item 1C)

1B. PROVIDE RATIONALE (e.g., veteran does not currently have any known stomach or duodenum condition):

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

- |  |                 |                          |
|--|-----------------|--------------------------|
| <input type="checkbox"/> GASTRIC ULCER   | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> DUODENAL ULCER  | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> STENOSIS OF THE STOMACH   | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> MARGINAL (GASTROJEJUNAL) ULCER                                  | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> HYPERTROPHIC GASTRITIS  | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> POSTGASTRECTOMY SYNDROME  | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> STATUS POST VAGOTOMY WITH PYLOROPLASTY                          | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> GASTROENTEROSTOMY   | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> PERITONEAL ADHESIONS FOLLOWING INJURY OR SURGERY OF THE STOMACH | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> HELICOBACTER PYLORI   | ICD Code: _____ | Date of Diagnosis: _____ |
| <input type="checkbox"/> OTHER STOMACH OR DUODENAL CONDITIONS                            |                 |                          |

Other Diagnosis #1: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Other Diagnosis #2: \_\_\_\_\_ ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

1D. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO INFECTIOUS INTESTINAL 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. 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**

3A. 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):

0  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):

0  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):

0  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):

0  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):

0  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):

0  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**

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

YES  NO

*(If checked, describe incapacitating episodes):*

*(Indicate frequency of incapacitating episodes per year):*

0  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**

5A. 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
- Atrophic gastritis
- 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

Postgastrectomy syndrome

*(If checked, indicate severity):*

- No symptoms or findings
- Mild; infrequent episodes of epigastric distress with characteristic mild circulatory symptoms after meals but with diarrhea and weight loss
- 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 - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS**

6A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

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 the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches))?*

YES  NO

*(If "Yes," also complete a Scars Questionnaire.)*

**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. The diagnosis of gastric or duodenal ulcer or stenosis can be made by upper gastrointestinal imaging series or endoscopy.

7A. HAVE DIAGNOSTIC IMAGING STUDIES OR OTHER DIAGNOSTIC PROCEDURES BEEN PERFORMED?

YES  NO

*(If "Yes," check all that apply):*

<input type="checkbox"/> Upper endoscopy	Date: _____	Results: _____
<input type="checkbox"/> Upper GI radiographic studies	Date: _____	Results: _____
<input type="checkbox"/> MRI	Date: _____	Results: _____
<input type="checkbox"/> CT	Date: _____	Results: _____
<input type="checkbox"/> Biopsy, specify site: _____	Date: _____	Results: _____
<input type="checkbox"/> Other, specify: _____	Date: _____	Results: _____

7B. HAS LABORATORY TESTING BEEN PERFORMED?

YES  NO

*(If "Yes," check all that apply):*

<input type="checkbox"/> CBC	Date of test: _____	Results: _____
<input type="checkbox"/> Hemoglobin: _____	Hematocrit: _____	White blood cell count: _____ Platelets: _____
<input type="checkbox"/> Helicobacter pylori	Date of test: _____	Results: _____
<input type="checkbox"/> 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 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 IX - REMARKS**

9. REMARKS *(If any)*

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

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

10A. PHYSICIAN'S SIGNATURE		10B. PHYSICIAN'S PRINTED NAME	10C. DATE SIGNED
10D. PHYSICIAN'S PHONE NUMBER	10E. PHYSICIAN'S MEDICAL LICENSE NUMBER	10F. 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](http://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, 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 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](http://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.