OMB Approved No. 2900-XXXX
Respondent Burden: 15 minutes

Department of Veterans Affairs

ARTHRITIS 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

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.

NOTE: Complete this questionnaire if the veteran has an inflammatory, autoimmune, crystalline or infectious arthritis, or another inflammatory or autoimmune condition. If the veteran has degenerative arthritis *(osteoarthritis)* or traumatic arthritis, do not complete this questionnaire, INSTEAD complete the Joint Questionnaire for the affected area *(e.g., if the diagnosis is osteoarthritis of the knee, complete the VA Form 21-0960M-9, Knee and Lower Leg Conditions Disability Benefits Questionnaire)*.

If the veteran has arthritis due to systemic lupus erythematosus *(SLE)*, INSTEAD complete the VA Form 21-0960I-4, Systemic Lupus Erytematous *(SLE)* and Other Immune System Disorders *(except HIV)* Disability Benefits Questionnaire.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN HAVE INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE OR INFECTIOUS ARTHRITIS?

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

1B. PROVIDE RATIONALE *(e.g. veteran does not currently have inflammatory, autoimmune, crystalline or infectious arthritis)*

1C. INDICATE DIAGNOSIS:

☐ GOUT	ICD CODE(S): _____	DATE OF DIAGNOSIS: _____
☐ RHEUMATOID ARTHRITIS *(atrophic)*	ICD CODE(S): _____	DATE OF DIAGNOSIS: _____
☐ GONORRHEAL ARTHRITIS	ICD CODE(S): _____	DATE OF DIAGNOSIS: _____
☐ PNEUMOCOCCIC ARTHRITIS	ICD CODE(S): _____	DATE OF DIAGNOSIS: _____
☐ TYPHOID ARTHRITIS	ICD CODE(S): _____	DATE OF DIAGNOSIS: _____
☐ SYPHILITIC ARTHRITIS	ICD CODE(S): _____	DATE OF DIAGNOSIS: _____
☐ STREPTOCOCCIC ARTHRITIS	ICD CODE(S): _____	DATE OF DIAGNOSIS: _____
☐ DYSBARIC OSTEONECROSIS *(Caisson Disease of Bone)*	ICD CODE(S): _____	DATE OF DIAGNOSIS: _____
☐ OTHER *(If checked, complete Item 1D)*		

1D. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE OR INFECTIOUS ARTHRITIS.

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1D. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE OR INFECTIOUS ARTHRITIS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE OR INFECTIOUS ARTHRITIS *(brief summary):*

2B. DOES THE VETERAN REQUIRE CONTINUOUS USE OF MEDICATION FOR THIS ARTHRITIS CONDITION?

☐ YES ☐ NO

(If "Yes," list only those medications used for this arthritis): _____

2C. HAS THE VETERAN LOST WEIGHT DUE TO THIS ARTHRITIS CONDITION?

☐ YES ☐ NO

(If "Yes," does the Veteran's weight loss attributable to this arthritis condition cause severe impairment of health?)

☐ YES ☐ NO

(If "Yes," provide baseline weight (average weight for 2-year period preceding onset of disease): _____ *, and current weight:* _____*.)*

SECTION II - MEDICAL HISTORY *(Continued)*

2D. DOES THE VETERAN HAVE ANEMIA DUE TO THIS ARTHRITIS CONDITION?

☐ YES ☐ NO

(If "Yes," does the Veteran's anemia attributable to this arthritis condition cause severe impairment of health?)

☐ YES ☐ NO *(If "Yes," provide CBC under diagnostic Section 9).*

SECTION III - JOINT INVOLVEMENT

3A. DOES THE VETERAN HAVE PAIN WITH JOINT MOVEMENT ATTRIBUTABLE TO THIS ARTHRITIS CONDITION?

☐ YES ☐ NO

(If "Yes," indicate affected joints (check all that apply)):

☐ CERVICAL SPINE ☐ THORACOLUMBAR SPINE

RIGHT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

LEFT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

(For all checked joints, describe involvement (brief summary). Also complete a Questionnaire for each affected joint, if indicated.)

3B. DOES THE VETERAN HAVE ANY LIMITATION OF JOINT MOVEMENT ATTRIBUTABLE TO THIS ARTHRITIS CONDITION?

☐ YES ☐ NO

(If "Yes," indicate affected joints (check all that apply)):

☐ CERVICAL SPINE ☐ THORACOLUMBAR SPINE

RIGHT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

LEFT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

(For all checked joints, describe limitation of movement (brief summary). Also complete a Questionnaire for each affected joint, if indicated.)

3C. DOES THE VETERAN HAVE ANY JOINT DEFORMITIES ATTRIBUTABLE TO THIS ARTHRITIS CONDITION?

☐ YES ☐ NO

(If "Yes," indicate affected joints (check all that apply)):

☐ CERVICAL SPINE ☐ THORACOLUMBAR SPINE

RIGHT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

LEFT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

(For all checked joints, describe deformities (brief summary). Also complete a Questionnaire for each affected joint, if indicated.)

SECTION IV - SYSTEMIC INVOLVEMENT OTHER THAN JOINTS

4. DOES THE VETERAN HAVE ANY INVOLVEMENT OF ANY SYSTEMS, OTHER THAN JOINTS, ATTRIBUTABLE TO THIS ARTHRITIS CONDITION?

☐ YES ☐ NO

(If "Yes," indicate systems involved (check all that apply)):

☐ OPHTHALMOLOGICAL ☐ SKIN AND MUCOUS MEMBRANES ☐ HEMATOLOGIC ☐ PULMONARY ☐ CARDIAC

☐ NEUROLOGIC ☐ RENAL ☐ GASTROINTESTINAL ☐ VASCULAR

(For all checked systems, describe involvement (brief summary). Also complete the appropriate Questionnaire if indicated.)

SECTION V - INCAPACITATING AND NON-INCAPACITATING EXACERBATION

5A. DUE TO THE ARTHRITIS CONDITION, DOES THE VETERAN HAVE EXACERBATIONS WHICH ARE NOT INCAPACITATING?

☐ YES ☐ NO

(If "Yes," indicate frequency of non-incapacitating exacerbations per year):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 OR MORE

Date of most recent non-incapacitating exacerbation: _____

Duration of most recent non-incapacitating exacerbation: _____

Describe non-incapacitation exacerbation: _____

5B. DUE TO THE ARTHRITIS CONDITION, DOES THE VETERAN HAVE EXACERBATIONS WHICH ARE INCAPACITATING?

☐ YES ☐ NO

(If "Yes," describe): _____

(Indicate frequency of incapacitating exacerbations per year):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 OR MORE

Date of most recent incapacitating exacerbation: _____

Duration of most recent incapacitating exacerbation: _____

Describe incapacitation exacerbation: _____

5C. DUE TO THE ARTHRITIS CONDITION, DOES THE VETERAN HAVE CONSTITUTIONAL MANIFESTATIONS ASSOCIATED WITH ACTIVE JOINT INVOLVEMENT WHICH ARE TOTALLY INCAPACITATING?

☐ YES ☐ NO

(If "Yes," has the Veteran been totally incapacitated due to this during the past 12 months?)

☐ YES ☐ NO

(If "Yes," indicate the total duration of incapacitation over the past 12 months):

☐ LESS THAN 1 WEEK
☐ 1 WEEK TO LESS THAN 2 WEEKS
☐ 2 WEEKS TO LESS THAN 4 WEEKS
☐ 4 WEEKS TO LESS THAN 6 WEEKS
☐ 6 WEEKS OR MORE

(Describe constitutional manifestations and the manner in which those manifestations cause incapacitation):

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," also complete a Scars Questionnaire.)*

SECTION VII - ASSISTIVE DEVICES

7A. DOES THE VETERAN USE ANY ASSISTIVE DEVICE(S) AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

☐ YES ☐ NO

(If "Yes," identify assistive device(s) used (check all that apply and indicate frequency)):

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Brace(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutch(es)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

SECTION VII - ASSISTIVE DEVICES *(Continued)*

7B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION

SECTION VIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

8. DUE TO THE VETERAN'S INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE OR INFECTIOUS ARTHRITIS, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTION REMAINS OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS?
(Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)

☐ YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROSTHESIS WOULD EQUALLY SERVE THE VETERAN

☐ NO

(If "Yes," indicate extremity(ies) for which this applies):

☐ RIGHT UPPER ☐ LEFT UPPER ☐ RIGHT LOWER ☐ LEFT LOWER

(For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary)):

SECTION IX - DIAGNOSTIC TESTING

NOTE - The diagnosis of arthritis must be confirmed by imaging studies. Once arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

9A. HAVE IMAGING STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

(If "Yes," indicate type of study):

☐ X-RAY Area imaged: _____ Date: _____ Results: _____

☐ OTHER, SPECIFY: _____

Area imaged: _____ Date: _____ Results: _____

9B. HAVE LABORATORY STUDIES BEEN PERFORMED? *(Note: Once a diagnosis has been confirmed, laboratory studies are not indicated for a disability exam.)*

☐ YES ☐ NO

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

☐ ERYTHROCYTE SEDIMENTATION RATE *(ESR)* Date of test: _____ Results: _____

☐ C-REACTIVE PROTEIN Date of test: _____ Results: _____

☐ RHEUMATOID FACTOR *(RF)* Date of test: _____ Results: _____

☐ ANTI-DNA ANTIBODIES Date of test: _____ Results: _____

☐ ANTINUCLEAR ANTIBODIES *(ANA)* Date of test: _____ Results: _____

☐ ANTI-CYCLIC CITRULLINATED PEPTIDE (ANTI-CCP) ANTIBODIES Date of test: _____ Results: _____

☐ CBC Date of test: _____

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

☐ OTHER, SPECIFY: _____ Date of test: _____ Results: _____

9C. HAS THE VETERAN HAD A JOINT ASPIRATION/SYNOVIAL FLUID ANALYSIS? *(Note: Once a diagnosis has been confirmed, testing is not indicated for a disability exam.)*

☐ YES ☐ NO

(If "Yes," indicate joint aspirated, date and results): _____

9D. HAS THE VETERAN HAD A BIOPSY *(e.g., skin, nerve, fat, rectum, kidney)? (Note: Once a diagnosis has been confirmed, testing is not indicated for a disability exam.)*

☐ YES ☐ NO

(If "Yes," indicate area biopsied, date and results): _____

9E. 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 X - FUNCTIONAL IMPACT

10. DOES THE VETERAN'S INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE OR INFECTIOUS ARTHRITIS CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the veteran's arthritis conditions, providing one or more examples):*

SECTION XI - REMARKS

11. REMARKS *(If any)*

SECTION XII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

12A. PHYSICIAN'S SIGNATURE	12B. PHYSICIAN'S PRINTED NAME	12C. DATE SIGNED

12D. PHYSICIAN'S PHONE NUMBER	12E. PHYSICIAN'S MEDICAL LICENSE NUMBER	12F. 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 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.