OMB Control No. 2900-xxxx
Respondent Burden: 15 minutes

Department of Veterans Affairs

ENDOCRINE DISEASES (Other than Thyroid, Parathyroid or Diabetes Mellitus) 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 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.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN HAVE OR HAS HE/SHE EVER HAD AN ENDOCRINE CONDITION? (This is the condition the veteran is claiming or for which an exam has been requested)

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

1B. SELECT THE VETERAN'S CONDITION (Check all that apply)

	ICD code	Date of diagnosis
☐ CUSHING'S SYNDROME	ICD code - _____	Date of diagnosis - _____
☐ ACROMEGALY	ICD code - _____	Date of diagnosis - _____
☐ DIABETES INSIPIDUS	ICD code - _____	Date of diagnosis - _____
☐ ADDISON'S DISEASE	ICD code - _____	Date of diagnosis - _____
☐ POLYGLANDULAR (Pluriglandular) SYNDROME	ICD code - _____	Date of diagnosis - _____
☐ HYPOPITUITARISM	ICD code - _____	Date of diagnosis - _____
☐ HYPERPITUITARISM	ICD code - _____	Date of diagnosis - _____
☐ HYPERALDOSTERONISM	ICD code - _____	Date of diagnosis - _____
☐ PHEOCHROMOCYTOMA	ICD code - _____	Date of diagnosis - _____
☐ HYPOGONADISM	ICD code - _____	Date of diagnosis - _____
☐ OSTEOPOROSIS	ICD code - _____	Date of diagnosis - _____
☐ OTHER (specify):		
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 ENDOCRINE CONDITION(S), LIST USING ABOVE FORMAT:

NOTE: If there are any cardiovascular, psychiatric, eye, skin or skeletal complications attributable to an endocrine condition, ALSO complete appropriate questionnaires if indicated.

SECTION II - MEDICAL RECORD REVIEW

2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARATION OF THIS REPORT

☐ C-FILE (VA ONLY)

☐ OTHER, describe:_____

SECTION III - MEDICAL HISTORY

3A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S ENDOCRINE CONDITION (brief summary):

3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF AN ENDOCRINE CONDITION?

☐ YES ☐ NO

(If "Yes," specify the condition and list only those medications required for the veteran's endocrine condition):_____

3C. HAS THE VETERAN HAD SURGERY FOR AN ENDOCRINE CONDITION?

☐ YES ☐ NO

(If "Yes," specify the condition and type of surgery):_____

(Date of surgery):_____

3D. HAS THE VETERAN HAD ANY OTHER TYPE OF TREATMENT FOR AN ENDOCRINE CONDITION?

☐ YES ☐ NO

(If "Yes," specify the condition and type of treatment):_____

(Date of treatment):_____

SECTION IV - FINDINGS, SIGNS AND SYMPTOMS

4A. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO CUSHING'S SYNDROME:

☐ YES ☐ NO

(If "Yes," check all that apply)

- ☐ STRIAE
- ☐ OBESITY
- ☐ MOON FACE
- ☐ GLUCOSE INTOLERANCE
- ☐ VASCULAR FRAGILITY
- ☐ LOSS OF MUSCLE STRENGTH
- ☐ ENLARGEMENT OF PITUITARY OR ADRENAL GLAND
- ☐ AS ACTIVE, PROGRESSIVE DISEASE INCLUDING LOSS OF MUSCLE STRENGTH
- ☐ OSTEOPOROSIS
- ☐ HYPERTENSION
- ☐ WEAKNESS
- ☐ OTHER (Specify)_____

(FOR ALL CHECKED CONDITIONS COMPLETE ITEM 4B)

4B. DESCRIBE ANY CHECKED CONDITIONS:

SECTION V - ACROMEGALY

5A. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO ACROMEGALY?

☐ YES ☐ NO

(If "Yes," check all that apply)

- ☐ ENLARGEMENT OF ACRAL PARTS
- ☐ OVERGROWTH OF LONG BONES
- ☐ ENLARGED SELLA TURCICA
- ☐ ARTHROPATHY
- ☐ GLUCOSE INTOLERANCE
- ☐ HYPERTENSION (If checked, provide BPx3):_____
- ☐ EVIDENCE OF INCREASED INTRACRANIAL PRESSURE (such as visual field defect)
- ☐ CARDIOMEGALY
- ☐ OTHER (Specify):_____

(FOR ALL CHECKED CONDITIONS COMPLETE ITEM 5B)

5B. DESCRIBE ANY CHECKED CONDITIONS:

SECTION VI - DIABETES INSIPIDUS

6A. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO DIABETES INSIPIDUS?

☐ YES ☐ NO

(If "Yes," check all that apply)

- ☐ POLYURIA
- ☐ NEAR-CONTINUOUS THIRST
- ☐ EPISODES OF DEHYDRATION *NOT* REQUIRING PARENTERAL HYDRATION IN PAST 12 MONTHS
  (*If checked, indicate frequency of documented episodes in past 12 months)*
  - ☐ 0 ☐ 1 ☐ 2 ☐ More than 2
- ☐ EPISODES OF DEHYDRATION REQUIRING PARENTERAL HYDRATION IN PAST 12 MONTHS
  (*If checked, indicate frequency of documented episodes in past 12 months)*
  - ☐ 0 ☐ 1 ☐ 2 ☐ More than 2
- ☐ OTHER (Specify):_____

(FOR ALL CHECKED CONDITIONS COMPLETE ITEM 6B)

6B. DESCRIBE ANY CHECKED CONDITIONS:

SECTION VII - ADDISON'S DISEASE (ADRENAL CORTICAL HYPOFUNCTION)

7A. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO ADDISON'S DISEASE?

☐ YES ☐ NO

(If "Yes," check all that apply)

☐ CORTICOSTEROID THERAPY REQUIRED FOR CONTROL

☐ WEAKNESS

☐ FATIGABILITY

☐ ADDISONIAN CRISIS (acute adrenal insufficiency)
(*If checked, indicate frequency of Addisonian crises in past 12 months)*

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than 5

☐ ADDISONIAN "EPISODES"
(*If checked, indicate frequency of Addisonian "episodes" in past 12 months)*

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than 5

☐ OTHER (Specify):_____

(FOR ALL CHECKED CONDITIONS COMPLETE ITEM 7B)

7B. DESCRIBE ANY CHECKED CONDITIONS:

NOTE: An Addisonian crisis consists of the rapid onset of peripheral vascular collapse (with acute hypotension and shock), with findings that may include anorexia; nausea; vomiting; dehydration; profound weakness; pain in the abdomen; legs and back; fever; apathy and depressed mentation with possible progression to coma, renal shutdowh and death.
For VA purposes, an Addisonian "episode" is a less acute and less severe event than an Addisonian crisis and may consist of anorexia, nausea, vomiting, diarrhea, dehydration, weakness, malaise, orthostatic hypotension or hypoglycemia, but no peripheral vascular collapse.

SECTION VIII - OTHER ENDOCRINE CONDITIONS

8A. DOES THE VETERAN HAVE ANY OTHER ENDOCRINE CONDITIONS?

☐ YES ☐ NO *(If "Yes," complete Item 8B)*

8B. SPECIFY CONDITION AND DESCRIBE ANY CURRENT FINDINGS, SIGNS AND SYMPTOMS:

SECTION IX - TUMORS AND NEOPLASMS

9A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS ?

☐ YES ☐ NO *(If "Yes," complete Items 9B, 9C, 9D & 9E)*

9B. IS THE NEOPLASM:

☐ BENIGN ☐ MALIGNANT

9C. 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," complete Item 9C)*

9C. INDICATE TYPE OF TREATMENT THE VETERAN IS CURRENTLY UNDERGOING OR HAS COMPLETED *(Check all that apply)*

☐ TREATMENT COMPLETED, CURRENTLY IN WATCHFUL WAITING STATUS

☐ 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:_____

9D. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS 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 residual conditions and complications (brief summary)):*

9E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DESCRIBE USING THE ABOVE FORMAT:

SECTION X - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

10A. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ 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 VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)*

10B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS ?

☐ YES ☐ NO *(If "Yes," describe (brief summary))*

SECTION XI - DIAGNOSTIC TESTING

NOTE: If diagnostic test results are in the medical record and reflect the veteran's current endocrine condition, repeat testing is not required.

11A. HAVE IMAGING STUDIES BEEN PERFORMED?

☐ YES ☐ NO

(If "Yes," check all that apply)

☐ Magnetic resonance imaging (MRI) Date:_____ Results:_____

☐ Computed tomography (CT) Date:_____ Results:_____

☐ Other:_____ Date:_____ Results:_____

11B. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO *(If "Yes," indicate type of test, date and results)*

Type of test:_____ Date:_____ Results:_____

11C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO *(If "Yes," indicate type of test, date and results)*

Type of test or procedure:_____ Date:_____ Results:_____

SECTION XII - FUNCTIONAL IMPACT

12. DOES THE VETERAN'S ENDOCRINE CONDITION IMPACT HIS OR HER ABILITY TO WORK?

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

SECTION XIII - REMARKS

13. REMARKS *(If any)*

SECTION XIV - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

14A. PHYSICIAN'S SIGNATURE	14B. PHYSICIAN'S PRINTED NAME	14C. DATE SIGNED

14D. PHYSICIAN'S PHONE AND FAX NUMBER	14E. PHYSICIAN'S MEDICAL LICENSE NUMBER	14F. 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.