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

Department of Veterans Affairs

SKIN DISEASES 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.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS THE VETERAN HAD A SKIN CONDITION?

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

1B. PROVIDE RATIONALE *(e.g., veteran does not have any known skin conditions)*:

1C. Provide only diagnoses that pertain to skin conditions *(Indicate the category of skin condition, and then provide specific diagnosis in that category (check all that apply))*

☐ Dermatitis or eczema
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Infectious skin conditions *(including bacterial, fungal, viral, treponemal and parasitic skin conditions)*
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Bullous disorders
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Psoriasis
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Exfoliative dermatitis *(erythroderma)*
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Cutaneous manifestations of collagen-vascular diseases
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Palpulosquamous skin disorders
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Vitiligo
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Keratinization skin disorders
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Urticaria
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Vasculitis
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Erythema multiforme
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Acne
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Chloracne
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Alopecia
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Hyperhidrosis
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Tumors and neoplasms of the skin, including malignant melanoma
DIAGNOSIS: _____ ICD Code: _____ Date of Diagnosis: _____

☐ Other skin condition
Other diagnosis #1: _____ ICD Code: _____ Date of Diagnosis: _____

Other diagnosis #2: _____ ICD Code: _____ Date of Diagnosis: _____

Other diagnosis #3: _____ ICD Code: _____ Date of Diagnosis: _____

SECTION I - DIAGNOSIS *(Continued)*

1D. IF THERE ARE ADDITIONAL DIAGNOSIS THAT PERTAIN TO THE SKIN CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S SKIN CONDITIONS *(brief summary)*:

2B. DO ANY OF THE VETERAN'S SKIN CONDITIONS CAUSE SCARRING OR DISFIGUREMENT OF THE HEAD, FACE OR NECK?

☐ YES ☐ NO *(If, "Yes," indicate skin condition and describe scarring and/or disfigurement and complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire if appropriate)*

2C. DOES THE VETERAN HAVE ANY BENIGN OR MALIGNANT SKIN NEOPLASMS *(including malignant melanoma)*?

☐ YES ☐ NO *(If, "Yes," also complete the VA Form 21-0960O-1, Tumors and Neoplasms Disability Benefits Questionnaire)*

2D. DOES THE VETERAN HAVE ANY SYSTEMIC MANIFESTATIONS DUE TO ANY SKIN DISEASES *(such as fever, weight loss or hypoproteinemia associated with skin conditions such as erythroderma)*?

☐ YES ☐ NO *(If, "Yes," describe and complete additional questionnaires if appropriate)*

SECTION III - TREATMENT

3. HAS THE VETERAN BEEN TREATED WITH ORAL OR TOPICAL MEDICATIONS IN THE PAST 12 MONTHS FOR ANY SKIN CONDITION *(such as dermatitis, eczema, bullous disorders, psoriasis, infectious skin conditions, cutaneous manifestations of collagen-vascular diseases, papulosquamous disorders)*?

☐ YES ☐ NO

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

☐ Corticosteroids or other immunosuppressive medications

(If checked, list medication(s): _____

(Specify condition medication used for): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Antihistamines

(If checked, list medication(s): _____

(Specify condition medication used for): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Immunosuppressive retinoids

(If checked, list medication(s): _____

(Specify condition medication used for): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Sympathomimetics

(If checked, list medication(s): _____

(Specify condition medication used for): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Other oral medications

(If checked, list medication(s): _____

(Specify condition medication used for): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Topical corticosteroids

(If checked, list medication(s): _____

(Specify condition medication used for): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Other topical medications

(If checked, list medication(s): _____

(Specify condition medication used for): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

SECTION III - TREATMENT *(Continued)*

NOTE - If a medication is used for more than one condition, provide names of all conditions, name of medication used for each condition, and frequency of use for each condition in Item 9, "Remarks".

3B. HAS VETERAN HAD ANY TREATMENTS OR PROCEDURES IN THE PAST 12 MONTHS FOR SKIN CONDITIONS *(such as eczema, psoriasis, vitiligo, mycosis fungoides)*?

☐ YES ☐ NO *(If "Yes," check all that apply)*

☐ PUVA (photo-chemotherapy with psoralen and ultraviolet A) treatment

(If checked, list medication(s): _____

(Specify condition medication used for): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ UVB (ultraviolet B phototherapy) treatment

(If checked, list medication(s): _____

(Specify condition medication used for): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Electron beam therapy

(If checked, list medication(s): _____

(Specify condition medication used for): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Intensive light therapy

(If checked, list medication(s): _____

(Specify condition medication used for): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Other treatment

(If checked, list medication(s): _____

(Specify condition medication used for): _____

(Total duration of medication use in past 12 months):

☐ <6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

SECTION IV - DEBILITATING AND NON-DEBILITATING EPISODES

4A. HAS THE VETERAN HAD ANY DEBILITATING EPISODES IN THE PAST 12 MONTHS DUE TO ANY SKIN CONDITIONS *(such as urticaria, vasculitis, erythema multiforme, or toxic epidermal necrolysis?)*

☐ YES ☐ NO

If "Yes," specify condition causing debilitating episodes (for example, urticaria, vasculitis, erythema multiforme, or toxic epidermal necrolysis):

_____

Describe debilitating episodes (brief summary): _____

Number of debilitating episodes in past 12 months:

☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Response to treatment for debilitating episodes:

☐ Occurred despite ongoing immunosuppressive therapy

☐ Required treatment with intermittent systemic immunosuppressive therapy

☐ Responded to treatment with antihistamines or sympathomimetics

4B. HAS THE VETERAN HAD ANY NON-DEBILITATING EPISODES DUE TO SKIN CONDITIONS *(such as urticaria, vasculitis, or erythema multiforme)* IN THE PAST 12 MONTHS?

☐ YES ☐ NO

If "Yes," specify condition causing non-debilitating episodes:

_____

Describe episodes (brief summary): _____

Number of non-debilitating episodes in past 12 months:

☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Response to treatment for non-debilitating episodes:

☐ Occurred despite ongoing immunosuppressive therapy

☐ Required treatment with intermittent systemic immunosuppressive therapy

☐ Responded to treatment with antihistamines or sympathomimetics

NOTE - If the Veteran's debilitating and/or non-debilitating episodes are due to more than one condition, provide names of all conditions, indicating severity and frequency of episodes for each condition in Item 9, "Remarks".

SECTION V - PHYSICAL EXAM

5A. DOES THE VETERAN HAVE ANY VISIBLE SKIN CONDITIONS ON CURRENT EXAMINATION?

☐ YES ☐ NO

(If "Yes," specify the skin condition(s)) (check all that apply)

☐ Dermatitis ☐ Eczema ☐ Bullous disorders ☐ Psoriasis ☐ Acne ☐ Pseudofolliculitis barbae

☐ Cutaneous manifestations of collagen-vascular diseases ☐ Papulosquamous disorders

Other, specify: _____

5B. FOR EACH SKIN CONDITION, DESCRIBE APPEARANCE AND LOCATION

_____

_____

_____

5C. INDICATE APPROXIMATE TOTAL BODY AREA AFFECTED BY EACH SKIN CONDITION ON CURRENT EXAMINATION

Skin condition # 1: _____ ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ >40%

Skin condition # 2: _____ ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ >40%

Skin condition # 3: _____ ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ >40%

If the veteran has more than 3 visible skin conditions, list additional conditions and indicate % of total body surface area affected, using above format:

_____

_____

5D. INDICATE APPROXIMATE TOTAL **EXPOSED** BODY AREA (face, neck and hands) AFFECTED BY EACH SKIN CONDITION ON CURRENT EXAMINATION

Skin condition # 1: _____ ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ >40%

Skin condition # 2: _____ ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ >40%

Skin condition # 3: _____ ☐ None ☐ <5% ☐ 5% to <20% ☐ 20% to 40% ☐ >40%

If the veteran has more than 3 skin conditions, list additional conditions and indicate % of total **EXPOSED** body surface area affected, using above format:

_____

_____

SECTION VI - SPECIFIC SKIN CONDITIONS

6. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SKIN CONDITIONS: ACNE, CHLORACNE, VITILIGO, ALOPECIA OR HYPERHIDROSIS?

☐ YES ☐ NO

(If "Yes," indicate the skin condition and complete appropriate sections)

☐ Acne or chloracne

(If checked, indicate severity and location (check all that apply)):

- ☐ Superficial acne (comedones, papules, pustules, superficial cysts) of any extent
- ☐ Deep acne (deep inflamed nodules and pus-filled cysts
- ☐ Affects less than 40% of face and neck
- ☐ Affects 40% or more of face and neck
- ☐ Affects body areas other than face and neck

☐ Vitiligo

(If checked, indicate areas affected by vitiligo):

- ☐ Exposed areas affected
- ☐ No exposed areas affected

☐ Scarring alopecia

(If checked, indicate percent of scalp affected):

☐ <20% ☐ 20% to 40% ☐ >40%

☐ Alopecia areata

(If checked, indicate amount of hair loss):

☐ Hair loss limited to scalp and face ☐ Loss of all body hair ☐ Other, describe: _____

☐ Hyperhidrosis

(If checked, indicate severity):

☐ Able to handle paper or tools after treatment ☐ Unresponsive to treatment; unable to handle paper or tools

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

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

☐ YES ☐ NO *(If "Yes," describe):*

SECTION VII - FUNCTIONAL IMPACT AND REMARKS

8. DO ANY OF THE VETERAN'S SKIN CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

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

9. REMARKS *(if any)*

SECTION IX - 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 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.