OMB Approved No. 2900-0776
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 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, "Yes," complete Item 1B)*

1B. 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: _____

☐ Primary cutaneous 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)*

1C. 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

3A. HAS THE VETERAN BEEN TREATED WITH ORAL OR TOPICAL MEDICATIONS IN THE PAST 12 MONTHS FOR ANY SKIN CONDITION?

☐ YES ☐ NO

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

☐ Systemic 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 THE VETERAN HAD ANY TREATMENTS OR PROCEDURES OTHER THAN SYSTEMIC OR TOPICAL MEDICATIONS IN THE PAST 12 MONTHS FOR EXFOLIATIVE DERMATITIS OR PAPULOSQUAMOUS DISORDERS?

☐ 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 URTICARIA, PRIMARY CUTANEOUS 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

Characteristics of 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 OF UTICARIA, PRIMARY CUTANEOUS VASCULITIS, ERYTHEMA MULTIFORME, OR TOXIC EPIDERMAL NECROLYSIS IN THE PAST 12 MONTHS?

☐ YES ☐ NO

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

☐ Urticaria ☐ Primary cutaneous vasculitis ☐ Erythema multiforme ☐ Toxic epidermal necrolysis

Describe episodes (brief summary): _____

Number of non-debilitating episodes in past 12 months:

☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Characteristics of 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. INDICATE THE VETERAN'S VISIBLE SKIN CONDITIONS; INDICATE THE APPROXIMATE TOTAL BODY AREA AND APPROXIMATE TOTAL ***EXPOSED*** BODY AREA (face, neck and hands) AFFECTED ON CURRENT EXAMINATION (check all that apply)

		None	<5%	5% to <20%	20% to 40%	>40%
☐ Dermatitis	Total body area	☐	☐	☐	☐	☐
	EXPOSED area	☐	☐	☐	☐	☐
☐ Eczema	Total body area	☐	☐	☐	☐	☐
	EXPOSED area	☐	☐	☐	☐	☐
☐ Bullous disorders	Total body area	☐	☐	☐	☐	☐
	EXPOSED area	☐	☐	☐	☐	☐
☐ Psoriasis	Total body area	☐	☐	☐	☐	☐
	EXPOSED area	☐	☐	☐	☐	☐
☐ Infections of the skin	Total body area	☐	☐	☐	☐	☐
	EXPOSED area	☐	☐	☐	☐	☐
☐ Cutaneous manifestations ofcollagen-vascular diseases	Total body area	☐	☐	☐	☐	☐
	EXPOSED area	☐	☐	☐	☐	☐
☐ Papulosquamous disorder	Total body area	☐	☐	☐	☐	☐
	EXPOSED area	☐	☐	☐	☐	☐

☐ The veteran does not have any of the above listed visible skin conditions

5B. FOR EACH SKIN CONDITION CHECKED IN ITEM 5A, GIVE SPECIFIC DIAGNOSIS AND DESCRIBE APPEARANCE AND LOCATION:

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 - TUMORS AND NEOPLASMS

7A. 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 7B through 7E)*

7B. IS THE NEOPLASM

☐ BENIGN ☐ MALIGNANT

7C. 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," 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, if checked date of most recent treatment_____ Date of completion of treatment or anticipated date of completion:_____

☐ Antineoplastic chemotherapy, if checked 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:_____

7D. 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)*

7E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS DESCRIBE USING THE ABOVE FORMAT

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

8. 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):*

SECTION IX - FUNCTIONAL IMPACT

9. 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):*

SECTION X - REMARKS

10. REMARKS *(if any)*

SECTION XI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

11A. PHYSICIAN'S SIGNATURE	11B. PHYSICIAN'S PRINTED NAME	11C. DATE SIGNED

11D. PHYSICIAN'S PHONE AND FAX NUMBER	11E. PHYSICIAN'S MEDICAL LICENSE NUMBER	11F. 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.