OMB Control No. 2900-0778
Respondent Burden: 15 Minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

GALLBLADDER AND PANCREAS CONDITIONS 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

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. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A GALLBLADDER OR PANCREAS CONDITION?

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

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

☐ Chronic cholecystitis	ICD Code: _____	Date of Diagnosis: _____
☐ Chronic cholelithiasis	ICD Code: _____	Date of Diagnosis: _____
☐ Chronic cholangitis	ICD Code: _____	Date of Diagnosis: _____
☐ Cholecystectomy	ICD Code: _____	Date of Diagnosis: _____
☐ Pancreatitis	ICD Code: _____	Date of Diagnosis: _____
☐ Total or partial pancreatectomy	ICD Code: _____	Date of Diagnosis: _____
☐ Gallbladder neoplasm	ICD Code: _____	Date of Diagnosis: _____
☐ Pancreatic neoplasm	ICD Code: _____	Date of Diagnosis: _____
☐ Gallbladder or pancreas injury, with peritoneal adhesions resulting from this injury	ICD Code: _____	Date of Diagnosis: _____

(If checked, ALSO complete VA Form 21-0960G-6, Peritoneal Adhesions Disability Benefits Questionnaire)

☐ Other gallbladder conditions:

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 GALLBLADDER OR PANCREAS CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S GALLBLADDER AND/OR PANCREAS CONDITION *(brief summary):*

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S GALLBLADDER OR PANCREAS CONDITION?

☐ YES ☐ NO *(If "Yes," list only those medications required for the gallbladder or pancreas condition):*

SECTION III - GALLBLADDER CONDITIONS: SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY GALLBLADDER CONDITIONS OR RESIDUALS OF TREATMENT FOR GALLBLADDER CONDITIONS?

☐ YES ☐ NO

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

☐ Gallbladder disease-induced dyspepsia *(including sphincter of oddi dysfunction and/or biliary dyskinesia)*
(If checked, indicate number of episodes per year):
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

☐ Attacks of gallbladder colic
(If checked, indicate number of attacks per year):
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

☐ Jaundice
(If checked, provide bilirubin level in Section VI, Diagnostic Testing)

☐ Other signs or symptoms, describe: _____

SECTION IV - PANCREAS CONDITIONS: SIGNS AND SYMPTOMS

4A. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SYMPTOMS ATTRIBUTABLE TO ANY PANCREAS CONDITIONS OR RESIDUALS OF TREATMENT FOR PANCREAS CONDITIONS?

☐ YES ☐ NO

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

☐ Abdominal pain, confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies
(If checked, indicate severity and frequency of attacks, check all that apply):
☐ Mild (typical) ☐ Moderately Severe ☐ Severe (disabling)
(Indicate number of attacks of MILD (TYPICAL) abdominal pain in the past 12 months):
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more
(Indicate number of attacks of MODERATELY SEVERE abdominal pain in the past 12 months):
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more
(Indicate number of attacks of SEVERE (DISABLING) abdominal pain in the past 12 months):
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

☐ Remissions/pain-free intermissions between attacks
(If checked, indicate characteristics of remissions):
☐ Good pain-free remissions between attacks
☐ Few pain-free intermissions between attacks
☐ Continuing pancreatic insufficiency between attacks

☐ Other symptoms, describe: _____

4B. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR FINDINGS ATTRIBUTABLE TO ANY PANCREAS CONDITIONS OR RESIDUALS OF TREATMENT FOR PANCREAS CONDITIONS?

☐ YES ☐ NO

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

☐ Steatorrhea
(If checked, describe frequency and severity): _____

☐ Malabsorption
(If checked, describe frequency and severity): _____

☐ Diarrhea
(If checked, describe frequency and severity): _____

☐ Severe malnutrition
(If checked, describe deficiency (such as beta-carotene, fat-soluble vitamin deficiencies)): _____

☐ 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).

☐ Other, describe: _____

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

5A. 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 in a brief summary):

SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS *(Continued)*

5B. 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 or equal to 39 square cm (6 square inches)?)

☐ YES ☐ NO

(If "Yes," also complete a VA Form 21-0960F-1 Scars/Disfigurement Disability Benefits Questionnaire)

SECTION VI - DIAGNOSTIC TESTING

NOTE: Diagnosis of pancreatitis must be confirmed by appropriate laboratory and clinical studies. If testing has been performed and reflects veteran's current condition, no further testing is required for this examination report.

6A. HAVE IMAGING STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

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

☐ EUS *(Endoscopic ultrasound)* Date: _____ Results: _____

☐ ERCP *(Endoscopic retrograde cholangiopancreatography)* Date: _____ Results: _____

☐ Transhepatic cholangiogram Date: _____ Results: _____

☐ MRI or MRCP *(magnetic resonance cholangiopancreatography)* Date: _____ Results: _____

☐ Gallbladder scan *(HIDA scan or cholescintigraphy)* Date: _____ Results: _____

☐ CT Date: _____ Results: _____

☐ Other, specify: _____ Date: _____ Results: _____

6B. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO

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

☐ Alkaline phosphatase Date: _____ Results: _____

☐ Bilirubin Date: _____ Results: _____

☐ WBC Date: _____ Results: _____

☐ Amylase Date: _____ Results: _____

☐ Lipase Date: _____ Results: _____

☐ Other, specify: _____ Date: _____ Results: _____

6C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO

(If "Yes," provide type of test or procedure, date and results in a brief summary):

SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S GALLBLADDER AND/OR PANCREAS CONDITION(S) IMPACT ON HIS OR HER ABILITY TO WORK?

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

SECTION VIII - REMARKS

8. 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.

9A. PHYSICIAN'S SIGNATURE	9B. PHYSICIAN'S PRINTED NAME	9C. DATE SIGNED

9D. PHYSICIAN'S PHONE AND FAX NUMBER	9E. PHYSICIAN'S MEDICAL LICENSE NUMBER	9F. 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.benefits.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 voluntary. 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. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.