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

Department of Veterans Affairs

BREAST CONDITIONS AND DISORDERS 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. 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 HAD A DISORDER OF THE BREAST(S)?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO THE BREAST(S)

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

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO THE BREAST(S), LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

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

2B. DOES THE VETERAN HAVE, OR HAVE A HISTORY, OF A NEOPLASM OF THE BREAST?

☐ YES ☐ NO *(If "Yes," complete Items 2C and 2D)*

2C. IS OR WAS THERE A MALIGNANT NEOPLASM?

☐ YES ☐ NO *(If "Yes," indicate which breast):* ☐ RIGHT ☐ LEFT ☐ BOTH

(If "Yes," were there or are there currently any metastases?): ☐ YES ☐ NO

(If "Yes," describe locations): _____

2D. IS OR WAS THERE A BENIGN NEOPLASM?

☐ YES ☐ NO

(If "Yes," indicate which breast): ☐ RIGHT ☐ LEFT ☐ BOTH

SECTION III - TREATMENT/SURGERY

3A. HAS THE VETERAN COMPLETED ANY TYPE OF TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM AND/OR METASTASES?

☐ YES ☐ NO; WATCHFUL WAITING

(If "Yes," indicate treatment type(s) - check all that apply):

☐ 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: _____
Side ☐ RIGHT ☐ LEFT ☐ BOTH

☐ Antineoplastic chemotherapy
Date of most recent treatment: _____
Date of completion of treatment or anticipated date of completion: _____

☐ Other therapeutic procedure and/or treatment *(describe):* _____
Date of procedure: _____
Date of completion of treatment or anticipated date of completion: _____

SECTION III - TREATMENT/SURGERY *(Continued)*

3B. HAS THE VETERAN UNDERGONE BREAST SURGERY?

☐ YES ☐ NO

(If "Yes," indicate procedure type and severity (check all that apply)):

☐ Wide local excision *(For VA purposes, wide local excision means removal of a portion of the breast tissue and includes partial mastectomy, lumpectomy, tylectomy, segmentectomy, and quadrantectomy)*
☐ Right ☐ Left ☐ Both

☐ Simple *(or total)* mastectomy *(For VA purposes, a simple (or total) mastectomy means removal of all of the breast tissue, nipple, and a small portion of the overlying skin, but lymph nodes and muscles are left intact)*
☐ Right ☐ Left ☐ Both

☐ Modified radical mastectomy *(For VA purposes, a modified radical mastectomy means removal of the entire breast and axillary lymph nodes, in continuity with the breast, with pectoral muscles left intact)*
☐ Right ☐ Left ☐ Both

☐ Radical mastectomy *(For VA purposes, radical mastectomy means removal of the entire breast, underlying pectoral muscles, and regional lymph nodes up to the coracoclavicular ligament)*
☐ Right ☐ Left ☐ Both

☐ Axillary or sentinel lymph node excision	☐ Right	☐ Left	☐ Both
☐ Significant alteration of size or form	☐ Right	☐ Left	☐ Both
☐ Biopsy	☐ Right	☐ Left	☐ Both
☐ Other: _____	☐ Right	☐ Left	☐ Both

3C. ARE THERE ANY RESIDUAL CONDITIONS CAUSED BY THE BENIGN OR MALIGNANT NEOPLASM OR ITS TREATMENT *(e.g., arm swelling, nerve damage to arm)?*

☐ YES ☐ NO

(If "Yes," briefly describe the conditions and complete appropriate Questionnaire):

SECTION IV - OBJECTIVE FINDINGS AND RESIDUALS

4. DID THE SURGERY OR RADIATION TREATMENT RESULT IN THE LOSS OF 25 PERCENT OR MORE TISSUE FROM A SINGLE BREAST OR BOTH BREASTS IN COMBINATION?

☐ YES ☐ NO

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

5A. 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 the VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)*

5B. 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 VI - DIAGNOSTIC TESTING

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

6. HAS THE VETERAN HAD IMAGING AND/OR DIAGNOSTIC TESTING AND IF SO, ARE THERE SIGNIFICANT FINDINGS AND/OR RESULTS?

☐ YES ☐ NO

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

SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S BREAST CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the veteran's breast 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 NUMBERS	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, 58/VA21/22/28, 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 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.