OMB Approved No. 2900-0779
Respondent Burden: 15 Minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

# PERSIAN GULF AND AFGHANISTAN INFECTIOUS 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. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

**IMPORTANT** - This questionnaire is intended solely for claims based on 38 CFR 3.317(c) ***Presumptive Service Connection for Infectious Disease***. Therefore, this questionnaire should only be completed for veterans who have or have had one or more of the following diseases/infections of the following agents: brucellosis, campylobacteriosis (Campylobacter jejuni), Q-fever (Coxiella burnetii), malaria, tuberculosis (Mycobacterium tuberculosis), nontyphoid Salmonella, shigellosis (Shigella), visceral leishmaniasis, or West Nile virus.

## SECTION I - DIAGNOSIS

1. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH ANY OF THE INFECTIOUS DISEASES LISTED BELOW?

☐ YES ☐ NO

*(If "Yes," indicate the infectious disease(s)/agent(s) that the veteran now has or has been diagnosed with):*

| | | | | |
|---|---|---|---|---|
| ☐ | BRUCELLOSIS | ICD CODE: | | DATE OF DIAGNOSIS: |
| ☐ | CAMPYLOBACTER JEJUNI | ICD CODE: | | DATE OF DIAGNOSIS: |
| ☐ | COXIELLA BURNETII *(Q FEVER)* | ICD CODE: | | DATE OF DIAGNOSIS: |
| ☐ | MALARIA | ICD CODE: | | DATE OF DIAGNOSIS: |
| ☐ | NONTYPHOID SALMONELLA | ICD CODE: | | DATE OF DIAGNOSIS: |
| ☐ | SHIGELLA | ICD CODE: | | DATE OF DIAGNOSIS: |
| ☐ | VISCERAL LEISHMANIASIS | ICD CODE: | | DATE OF DIAGNOSIS: |
| ☐ | WEST NILE VIRUS | ICD CODE: | | DATE OF DIAGNOSIS: |
| ☐ | MYCOBACTERIUM TUBERCULOSIS *(TB)** | ICD CODE: | | DATE OF DIAGNOSIS: |

*If TB is the only diagnosis checked, do not complete the rest of this questionnaire, instead complete VA Form 21-0960I-6, Tuberculosis Disability Benefits Questionnaire. If any other disease(s) have been checked along with mycobacterium tuberculosis, complete the VA Form 21-0960I-6, Tuberculosis Disability Benefits Questionnaire for all Tuberculosis-Related conditions, and ALSO complete this questionnaire, Persian Gulf and Afghanistan Infectious Diseases Disability Benefits Questionnaire.

## SECTION II - MEDICAL HISTORY FOR DISEASE #1

2A. NAME OF DISEASE #1:

DESCRIBE HISTORY *(including onset and course)* OF THE VETERAN'S DISEASE #1:

2B. STATUS OF DISEASE #1: ☐ ACTIVE ☐ INACTIVE/TREATED AND RESOLVED

2C. IF INACTIVE, DATE DISEASE BECAME INACTIVE/RESOLVED:

2D. IF INACTIVE/RESOLVED, ARE THERE RESIDUALS DUE TO THE DISEASE?

☐ YES ☐ NO *(If "Yes," describe residuals):*

*(Also complete appropriate Questionnaire for each specific residual condition, if indicated.)*

## SECTION III - MEDICAL HISTORY FOR DISEASE #2

3A. NAME OF DISEASE #2:

DESCRIBE HISTORY *(including onset and course)* OF THE VETERAN'S DISEASE #2:

**SECTION III - MEDICAL HISTORY FOR DISEASE #2 *(Continued)***

3B. STATUS OF DISEASE #2: ☐ ACTIVE ☐ INACTIVE/TREATED AND RESOLVED

3C. IF INACTIVE, DATE DISEASE BECAME INACTIVE/RESOLVED: _____

3D. IF INACTIVE/RESOLVED, ARE THERE RESIDUALS DUE TO THE DISEASE?

☐ YES ☐ NO *(If "Yes," describe residuals):*

*(Also complete appropriate Questionnaire for each specific residual condition, if indicated.)*

**SECTION IV - MEDICAL HISTORY FOR DISEASE #3**

4A. NAME OF DISEASE #3:

DESCRIBE HISTORY *(including onset and course)* OF THE VETERAN'S DISEASE #3:

4B. STATUS OF DISEASE #3: ☐ ACTIVE ☐ INACTIVE/TREATED AND RESOLVED

4C. IF INACTIVE, DATE DISEASE BECAME INACTIVE/RESOLVED: _____

4D. IF INACTIVE/RESOLVED, ARE THERE RESIDUALS DUE TO THE DISEASE?

☐ YES ☐ NO *(If "Yes," describe residuals):*

*(Also complete appropriate Questionnaire for each specific residual condition, if indicated.)*

**SECTION V - ADDITIONAL GULF WAR INFECTIOUS DISEASES**

5. IF THE VETERAN HAS HAD ANY ADDITIONAL GULF WAR INFECTIOUS DISEASES, DESCRIBE USING ABOVE FORMAT:

**SECTION VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, SIGNS AND/OR SYMPTOMS**

6A. 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 VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire.)*

6B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS?

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

**SECTION VII - DIAGNOSTIC TESTING**

**NOTE:** If the veteran has had diagnostic testing for suspected or confirmed Gulf War infectious diseases and the results are in the medical record and reflect the veteran's current status, repeat testing is not indicated.

7. ARE THERE ANY SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO *(If "Yes," provide type of test or procedure, date and results (brief summary)):*

## SECTION VIII - FUNCTIONAL IMPACT

8. DOES THE VETERAN'S GULF WAR INFECTIOUS DISEASE(S) IMPACT HIS OR HER ABILITY TO WORK?

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

## SECTION IX - REMARKS

9. REMARKS *(If any)*

## SECTION X - 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 AND FAX 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.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.