



**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 HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A SEIZURE DISORDER (*epilepsy*)? (*This is the condition the veteran is claiming or for which an exam has been requested*)

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

1B. SELECT THE APPROPRIATE DIAGNOSIS: (*check all that apply*):

- TONIC-CLONIC SEIZURES OR GRAND MAL EPILEPSY (*generalized convulsive seizures*) ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- ABSENCE SEIZURES OR PETIT MAL OR ATONIC SEIZURES (*generalized non-convulsive seizures*) ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- JACKSONIAN (*simple partial seizures*) ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- FOCAL MOTOR ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- FOCAL SENSORY ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- DIENCEPHALIC EPILEPSY ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- PSYCHOMOTOR EPILEPSY (*complex partial seizures, temporal lobe seizures*) ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- OTHER (*specify*)  
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 SEIZURE DISORDERS (*epilepsy*), LIST USING ABOVE FORMAT:

**SECTION II - MEDICAL RECORD REVIEW**

2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARATION OF THIS REPORT:

- C-FILE (VA ONLY)
- OTHER, DESCRIBE: \_\_\_\_\_

**SECTION III - MEDICAL HISTORY**

3A. DESCRIBE THE HISTORY (*including onset and course*) OF THE VETERAN'S SEIZURE DISORDER (*epilepsy*) (*brief summary*):

3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF EPILEPSY OR SEIZURE ACTIVITY?

YES  NO (*If "Yes," list only those medications required for the veteran's epilepsy or seizure activity*)

3C. HAS THE VETERAN HAD ANY OTHER TREATMENT (*such as surgery*) FOR EPILEPSY OR SEIZURE ACTIVITY?

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

3D. HAS THE DIAGNOSIS OF A SEIZURE DISORDER BEEN CONFIRMED?

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

3E. HAS THE VETERAN HAD A WITNESSED SEIZURE?

YES  NO (*If "Yes," describe, including relationship of witnesses to veteran*):

**SECTION IV - FINDINGS, SIGNS AND SYMPTOMS**

4. DOES THE VETERAN HAVE OR HAS HE OR SHE HAD ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO SEIZURE DISORDER (*epilepsy*) ACTIVITY?

- YES  NO (*If "Yes," check all that apply*)
- Generalized tonic-clonic convulsion
  - Episodes of unconsciousness
  - Brief interruption in consciousness or conscious control
  - Episodes of staring
  - Episodes of rhythmic blinking of the eyes
  - Episodes of nodding of the head
  - Episodes of sudden jerking movement of the arms, trunk or head (myoclonic type)
  - Episodes of sudden loss of postural control (akinetic type)
  - Episodes of complete or partial loss of use of one or more extremities
  - Episodes of random motor movements
  - Episodes of psychotic manifestations
  - Episodes of hallucinations
  - Episodes of perceptual illusions
  - Episodes of abnormalities of thinking
  - Episodes of abnormalities of memory
  - Episodes of abnormalities of mood
  - Episodes of autonomic disturbances
  - Episodes of speech disturbances
  - Episodes of impairment of vision
  - Episodes of disturbances of gait
  - Episodes of tremors
  - Episodes of visceral manifestations
  - Residuals of Injury during seizure
  - Other

(For all checked conditions describe):

**SECTION V - TYPE AND FREQUENCY OF SEIZURE ACTIVITY**

5A. DOES THE VETERAN HAVE OR HAS HE OR SHE EVER HAD ANY TYPE OF SEIZURE ACTIVITY, INCLUDING MAJOR, MINOR, PETIT MAL OR PSYCHOMOTOR SEIZURE ACTIVITY?

- YES  NO (*If "Yes," complete Items 5B through 5H*)

5B. PROVIDE APPROXIMATE DATE OF FIRST SEIZURE ACTIVITY (*Month, Year*) \_\_\_\_\_

PROVIDE DATE OF MOST RECENT SEIZURE ACTIVITY (*Month, Year*) \_\_\_\_\_

5C. HAS THE VETERAN EVER HAD MINOR SEIZURES (*characterized by a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head ("pure" petit mal) or sudden jerking movements of the arms, trunk or head (myoclonic type) or sudden loss of postural control (akinetic type)*)?

- YES  NO (*If "Yes," complete the following*):

**Number of minor seizures over past 6 months:**

- 0-1  
 2 or more

If 2 or more over the past 6 months, indicate the average frequency of minor seizures:

- 0-4 per week  5-8 per week  9-10 per week  More than 10 per week

4D. HAS THE VETERAN EVER HAD MAJOR SEIZURES (*characterized by the generalized tonic-clonic convulsion with unconsciousness*)?

- YES  NO (*If "Yes," complete the following*):

**Number of major seizures:**

- None in past 2 years  At least 1 in past 2 years  At least 2 in past year

**Average frequency of major seizures:**

- Less than 1 in past 6 months  
 At least 1 in past 6 months  
 At least 1 in 4 months over past year  
 At least 1 in 3 months over past year  
 At least 1 per month over past year

**SECTION IV - TYPE AND FREQUENCY OF SEIZURE ACTIVITY (Continued)**

5E. HAS THE VETERAN EVER HAD MINOR PSYCHOMOTOR SEIZURES (*characterized by brief transient episodes of random motor movements, hallucinations, perceptual illusions, abnormalities of thinking, memory or mood, or autonomic disturbances*)?

YES  NO (*If "Yes," complete the following*):

**Number of minor psychomotor seizures over past 6 months:**

0  1  2 or more

If 2 or more over the past 6 months, indicate the average frequency of minor psychomotor seizures:

- 0-4 per week
- 5-8 per week
- 9-10 per week
- More than 10 per week

5F. HAS THE VETERAN EVER HAD MAJOR PSYCHOMOTOR SEIZURES (*major psychomotor seizures are characterized by automatic states and/or generalized convulsions with unconsciousness*)?

YES  NO (*If "Yes," complete the following*):

**Number of major psychomotor seizures:**

- None in past 2 years
- At least 1 in past 2 years
- At least 2 in past year

**Average frequency of major psychomotor seizures:**

- Less than 1 in past 6 months
- At least 1 in past 6 months
- At least 1 in 4 months over past year
- At least 1 in 3 months over past year
- At least 1 per month over past year

5G. HAS THE VETERAN EVER HAD EPILEPSY ASSOCIATED WITH A NONPSYCHOTIC ORGANIC BRAIN SYNDROME?

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

5H. HAS THE VETERAN EVER HAD EPILEPSY ASSOCIATED WITH A PSYCHOTIC DISORDER, PSYCHONEUROTIC DISORDER OR PERSONALITY DISORDER?

YES  NO (*If "Yes," the appropriate Mental Disorder Questionnaire must ALSO be completed*)

**SECTION VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, 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 the VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire*)

6B. 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 VII - DIAGNOSTIC TESTING**

**NOTE** - If diagnostic test results are in the medical record and reflect the veteran's current seizure (epilepsy) disorder, repeat testing is not required.

7A. HAVE ANY IMAGING STUDIES OR DIAGNOSTIC PROCEDURES BEEN PERFORMED?

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

- |  |             |                |
|--|-------------|----------------|
| <input type="checkbox"/> Magnetic resonance imaging ( <i>MRI</i> ) | Date: _____ | Results: _____ |
| <input type="checkbox"/> Computed tomography ( <i>CT</i> )         | Date: _____ | Results: _____ |
| <input type="checkbox"/> Cerebrospinal fluid CSF examination       | Date: _____ | Results: _____ |
| <input type="checkbox"/> Electroencephalography ( <i>EEG</i> )     | Date: _____ | Results: _____ |
| <input type="checkbox"/> Neuropsychologic testing                  | Date: _____ | Results: _____ |
| <input type="checkbox"/> Other ( <i>describe</i> ): _____          | Date: _____ | Results: _____ |

7B. ARE THERE ANY OTHER 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 EPILEPSY OR SEIZURE (*epilepsy*) DISORDER IMPACT HIS OR HER ABILITY TO WORK?

YES  NO (*If "Yes," describe the impact of the veteran's seizure (epilepsy) disorder, 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](http://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](http://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.