OMB Approved No. 2900-0781
Respondent Burden: 30 Minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

# SYSTEMIC LUPUS ERYTEMATOUS (SLE) AND OTHER AUTOIMMUNE 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 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 HAVE OR HAS HE OR SHE HAD A SYSTEMIC OR LOCALIZED AUTOIMMUNE DISEASE, INCLUDING SYSTEMIC LUPUS ERYTHEMATOSUS *(SLE)*? *(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 VETERAN'S CONDITION:

☐ Autoimmune polyglandular syndrome ICD Code: _____ Date of diagnosis: _____
*(If this condition affects multiple endocrine glands, ALSO complete appropriate questionnaire(s) for those conditions)*

☐ Diabetes Mellitus Type I ICD Code: _____ Date of diagnosis: _____
*(If checked, ALSO complete VA Form 21-0960E-1, Diabetes Mellitus Disability Benefits Questionnaire)*

☐ Discoid lupus erythematosus ICD Code: _____ Date of diagnosis: _____

☐ Familial Mediterranean fever ICD Code: _____ Date of diagnosis: _____

☐ Goodpasture's syndrome ICD Code: _____ Date of diagnosis: _____
*(If this condition affects the lungs or kidneys, ALSO complete VA Form 21-0960L-1, Respiratory Conditions Disability Benefits Questionnaire or VA Form 21-0960J-1, Kidney Conditions Disability Benefits Questionnaire)*

☐ Guillain-Barre syndrome ICD Code: _____ Date of diagnosis: _____
*(If this condition affects the nervous system, ALSO complete VA Form 21-0960C-5, Central Nervous System Diseases Disability Benefits Questionnaire)*

☐ Immunodeficiency with hyper-IgM ICD Code: _____ Date of diagnosis: _____

☐ Polymyalgia rheumatica ICD Code: _____ Date of diagnosis: _____
*(If this condition affects large muscle groups, ALSO complete VA Form 21-0960M-10, Muscle Injuries Disability Benefits Questionnaire)*

☐ Rheumatoid arthritis (RA and Juvenile RA (JRA) ICD Code: _____ Date of diagnosis: _____
*(If this condition affects the joints, lungs or skin, ALSO complete the appropriate questionnaire (i.e., VA Form 21-0960M-3, VA Form 21-0960L-1, or VA Form 21-0960F-2)*

☐ Scleroderma ICD Code: _____ Date of diagnosis: _____
*(If this condition affects the skin, lungs or intestines, ALSO complete the appropriate questionnaire (i.e., VA Form 21-0960F-2, VA Form 21-0960L-1, VA Form 21-0960G-3 or VA Form 21-0960G-4 )*

☐ Severe combined immunodeficiency ICD Code: _____ Date of diagnosis: _____

☐ Sjögren's syndrome ICD Code: _____ Date of diagnosis: _____
*(If this condition affects the salivary glands, lacrimal glands, joints or kidneys, ALSO complete the appropriate questionnaire (i.e., VA Form 21-0960D-1, VA Form 21-0960M-3,VA Form 21-0960J-1)*

☐ Subacute cutaneous lupus erythematosus ICD Code: _____ Date of diagnosis: _____

☐ Systemic lupus erythematosus ICD Code: _____ Date of diagnosis: _____

☐ Temporal arteritis/Giant cell arteritis ICD Code: _____ Date of diagnosis: _____

☐ Wegener's granulomatosis ICD Code: _____ Date of diagnosis: _____
*(If this condition affects the blood vessels, sinuses, lungs or kidneys, ALSO complete the appropriate questionnaire (i.e., VA Form 21-0960A-2, VA Form 21-0960N-4,VA Form 21-0960L-1or VA Form 21-0960J-1)*

☐ Other, specify

Other diagnosis #1: _____ ICD Code: _____ Date of diagnosis: _____

Other diagnosis #2: _____ ICD Code: _____ Date of diagnosis: _____

*(NOTE: For all checked diagnoses, ALSO complete additional DBQ's as appropriate to fully describe effects of the condition)*
*(NOTE: If the veteran has been diagnosed with HIV, complete the VA Form 21-0960I-2, HIV-Related Illnesses Disability Benefits Questionnaire in lieu of this questionnaire)*
*(NOTE: If the veteran has been diagnosed with Diabetes Mellitus Type I, complete the VA Form 21-0960E-1, Diabetes Mellitus Disability Benefits Questionnaire in lieu of this questionnaire)*

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO AUTOIMMUNE DISEASES, 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 AUTOIMMUNE DISEASE, INCLUDING SLE *(brief summary)*:

3B. OVER THE PAST 12 MONTHS, HAS THE VETERAN'S TREATMENT PLAN INCLUDED ORAL OR TOPICAL MEDICATIONS FOR ANY AUTOIMMUNE DISEASE OR AUTOIMMUNE DISORDER-RELATED SKIN CONDITION, INCLUDING SYSTEMIC, CUTANEOUS OR DISCOID LUPUS?

☐ YES ☐ NO

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

☐ Oral corticosteroids

*(If checked, list medications and specify the condition medication is used for):*

Total duration of medication use in past 12 months?

☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

☐ Other immunosuppressive medications

*(If checked, list medications and specify the condition medication is 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 medications and specify the condition medication is 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 medications and specify the condition medication is 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 or topical medications used for an autoimmune condition

*(If checked, list medications and specify the condition medication is used for):*

Total duration of medication use in past 12 months?

☐ < 6 weeks ☐ 6 weeks or more, but not constant ☐ Constant/near-constant

3C. INDICATE STATUS OF THE VETERAN'S AUTOIMMUNE DISEASE, INCLUDING SLE:

☐ ACUTE ☐ CHRONIC ☐ OTHER *(describe):*

3D. DOES THE VETERAN HAVE EXACERBATIONS OF AN AUTOIMMUNE DISEASE, INCLUDING SLE?

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

Indicate average frequency of exacerbations per year:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ More than 3 exacerbations per year

Indicate average duration of symptoms during each exacerbation:

☐ Lasting less than one week

☐ Lasting a week or more

☐ Other *(describe):*

3E. DOES THE VETERAN'S AUTOIMMUNE DISEASE, INCLUDING SLE CURRENTLY PRODUCE SEVERE IMPAIRMENT OF HEALTH?

☐ YES ☐ NO *(If "Yes," describe the severe impairment of health):*

## SECTION IV - CUTANEOUS MANIFESTATIONS

4. DOES THE VETERAN HAVE ANY CUTANEOUS MANIFESTATIONS OF AN AUTOIMMUNE DISEASE, INCLUDING SYSTEMIC, CUTANEOUS OR DISCOID LUPUS ERYTGENATISYS?

☐ YES ☐ NO *(If "Yes," complete the following Items 4A thru 4F)*

A. Specify the cutaneous manifestations *(check all that apply)*

☐ Discoid lupus erythematosus
☐ Subacute cutaneous lupus erythematosus
☐ Other, describe: _____

B. Indicate areas affected by cutaneous manifestations *(check all that apply)*

☐ Malar rash over bridge of nose and bilateral cheeks, sparing nasolabial folds
☐ Cheeks *(If checked, specify which side):* ☐ Right ☐ Left ☐ Both
☐ Ears *(If checked, specify which side):* ☐ Right ☐ Left ☐ Both
☐ Nose
☐ Chin
☐ Lips and mouth, causing ulcers and scaling
☐ Hands
☐ Feet
☐ Scalp, causing scarring alopecia
☐ Other body areas, specify location: _____

***Note:*** *For all checked boxes in Item 4B, describe cutaneous manifestations:*

_____

_____

C. Indicate approximate TOTAL body area affected by cutaneous manifestations of an autoimmune disease on current examination:

☐ None ☐ < 5% ☐ 5% to < 20% ☐ 20% to 40% ☐ > 40%

D. Indicate approximate total EXPOSED body area *(face, neck and hands)* affected by cutaneous manifestations of an autoimmune disease on current examination:

☐ None ☐ < 5% ☐ 5% to < 20% ☐ 20% to 40% ☐ > 40%

E. Do the cutaneous manifestations of the autoimmune disease cause scarring alopecia?

☐ Yes ☐ No *(If "Yes," indicate percent of scalp affected):*

☐ < 20% ☐ 20% to 40% ☐ > 40%

F. Do the cutaneous manifestations of the autoimmune disease cause scarring *(including surgical scars related to the condition, if any)* that is unstable, painful, causes disfigurement of the head, face or neck, or has a 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)*

## SECTION V - FINDINGS, SIGNS AND SYMPTOMS

5. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS *(other than cutaneous manifestations)* ATTRIBUTABLE TO AN AUTOIMMUNE DISEASE, INCLUDING SLE?

☐ Yes ☐ No *(If "Yes," complete the following Items 5A thru 5D):*

A. Has the veteran had any symptoms *(other than cutaneous manifestations)* attributable to an autoimmune disease, including SLE, in the past 2 years?

☐ Yes ☐ No

B. Does the veteran have arthritis attributable to an autoimmune disease, including SLE?

☐ Yes ☐ No *(If "Yes," list affected joints and describe effect of autoimmune disease on each joint (brief summary) and ALSO complete the appropriate questionnaire for each affected joint):*

C. Does the veteran have recurrent ulcers on oral mucous membranes attributable to an autoimmune disease, including SLE?

☐ Yes ☐ No

*(If "Yes," do the recurrent ulcers result in impairment of mastication, a speech impairment or other signs or symptoms?)*

☐ Yes ☐ No *(If "Yes," describe):*

D. Does the veteran have any hematologic or lymphatic manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

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

☐ General adenopathy
☐ Splenomegaly
☐ Anemia
☐ Leukopenia *(usually lymphopenia, with < 1500 cells/uL)*
☐ Thrombocytopenia *(sometimes life-threatening autoimmune thrombocytopenia)*
☐ Other, describe: _____

## SECTION V - FINDINGS, SIGNS AND SYMPTOMS *(Continued)*

5. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS *(other than cutaneous manifestations)* ATTRIBUTABLE TO AN AUTOIMMUNE DISEASE, INCLUDING SLE? *(Continued)*

☐ Yes ☐ No *(If "Yes," complete the following section):*

E. Does the veteran have any pulmonary manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

*(If "Yes," check all that apply and ALSO complete VA Form 21-0960L-1, Respiratory Conditions Disability Benefits Questionnaire, including pulmonary function testing, if appropriate, on the questionnaire)*

- ☐ Pulmonary emboli
- ☐ Pulmonary hypertension
- ☐ Shrinking lung syndrome
- ☐ Recurrent pleurisy, with or without pleural effusion
- ☐ Other, describe: _____

F. Does the veteran have any cardiac manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

*(If "Yes," check all that apply and ALSO complete a VA Form 21-0960A-4, Heart Disease (including arrhythmias and surgery) Disability Benefits Questionnaire)*

- ☐ Percardial effusion
- ☐ Myocarditis
- ☐ Coronary artery vasculitis
- ☐ Valvular involvement
- ☐ Libman-Sacks endocarditis
- ☐ Other, describe: _____

G. Does the veteran have any neurologic manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

*(If "Yes," describe and ALSO complete the appropriate neurologic questionnaire (i.e., VA Form 21-0960C-8, Headaches Disability Benefits Questionnaire, VA Form 21-0960C-5 Central Nervous System and Neuromuscular System Diseases Disability Benefits Questionnaire or VA Form 21-0960C-9, Multiple Sclerosis Disability Benefits Questionnaire)*

H. Does the veteran have any renal manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

*(If "Yes," check all that apply and ALSO complete the VA Form 21-0960J-1, Kidney Conditions Disability Benefits Questionnaire and/or VA Form 21-0960A-3, Hypertension Disability Benefits Questionnaire)*

- ☐ Glomerular nephritis
- ☐ Membranoproliferative glomerulonephritis
- ☐ Proteinuria
- ☐ Hypertension
- ☐ Edema
- ☐ Other, describe: _____

I. Does the veteran have any obstetric manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No *(If "Yes," describe):* _____

J. Does the veteran have any gastrointestinal manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

*(If "Yes," describe and ALSO complete the appropriate GI questionnaire (i.e., VA Form 21-0960G-1, Esophageal Disorders Disability Benefits Questionnaire, VA Form 21-0960G-2, Gall Bladder and Pancreas Disability Benefits Questionnaire, VA Form 21-0960G-3, Intestines (other than surgical or infectious) Disability Benefits Questionnaire, VA Form 21-0960G-4, Intestines (surgical or infectious) Disability Benefits Questionnaire, VA Form 21-0960G-5, Hepatitis, Cirrhosis and other Liver Conditions Disability Benefits Questionnaire, VA Form 21-0960G-6, Peritoneal Adhesions Disability Benefits Questionnaire, and VA Form 21-0960G-7, Stomach and Duodenum Conditions Disability Benefits Questionnaire)*

K. Does the veteran have any vascular *(arterial or venus)* manifestations of an autoimmune disease, including SLE?

☐ Yes ☐ No

*(If "Yes," check all that apply and ALSO complete the VA Form 21-0960A-2, Artery and Vein Conditions Disease Disability Benefits Questionnaire)*

- ☐ Recurrent arterial thrombosis
- ☐ Recurrent venous thrombosis
- ☐ Other, describe: _____

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

6. 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

7. IF IMAGING STUDIES, DIAGNOSTIC PROCEDURES OR LABORATORY TESTING HAS BEEN PERFORMED AND REFLECTS THE VETERAN'S CURRENT CONDITION, PROVIDE MOST RECENT RESULTS AND NO FURTHER STUDIES OR TESTING ARE REQUIRED FOR THIS EXAMINATION ***(NOTE:** When appropriate provide **most recent** results)*

A. Have imaging studies been performed?

☐ YES ☐ NO

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

| | | | |
|---|---|---|---|
| ☐ Chest x-ray | Date: _____ | Results: _____ |
| ☐ Magnetic resonance imaging *(MRI)* | Date: _____ | Results: _____ |
| ☐ Computed tomography *(CT)* | Date: _____ | Results: _____ |
| ☐ Other, describe: _____ | Date: _____ | Results: _____ |

B. Has laboratory testing been performed?

☐ YES ☐ NO

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

| | | |
|---|---|---|
| ☐ Hemoglobin *(gm/100ml)* | Date: _____ | Results: _____ |
| ☐ Hematocrit | Date: _____ | Results: _____ |
| ☐ Red blood cell *(RBC)* count | Date: _____ | Results: _____ |
| ☐ White blood cell *(WBC)* count | Date: _____ | Results: _____ |
| ☐ White blood cell differential count | Date: _____ | Results: _____ |
| ☐ Platelet count | Date: _____ | Results: _____ |
| ☐ Erythrocyte sedimentation rate *(ESR)* | Date: _____ | Results: _____ |
| ☐ C-reactive protein *(CRP)* | Date: _____ | Results: _____ |
| ☐ Antinuclear antibody *(ANA)* titer | Date: _____ | Results: _____ |
| ☐ Anti-Ro Antibody | Date: _____ | Results: _____ |
| ☐ Anti-Smith antibodies | Date: _____ | Results: _____ |
| ☐ Anti-Ro double strand *(ds)* DNA | Date: _____ | Results: _____ |
| ☐ Antiphospolipid | Date: _____ | Results: _____ |
| ☐ Complement components *(C3 and C4)* | Date: _____ | Results: _____ |
| ☐ BUN | Date: _____ | Results: _____ |
| ☐ Creatinine | Date: _____ | Results: _____ |
| ☐ Estimated glomerular filtration rate *(EGFR)* | Date: _____ | Results: _____ |
| ☐ Other, specify: _____ | Date: _____ | Results: _____ |

C. Has a urinalysis been performed?

☐ YES ☐ NO

*(If "Yes," complete the following):*

Date of most recent urinalysis: _____

Results:

Microalbumin: ☐ Not elevated ☐ Elevated to: _____

Protein: ☐ None ☐ Trace ☐ 1+ ☐ 2+ ☐ 3+

Glucose: ☐ None ☐ Trace ☐ 1+ ☐ 2+ ☐ 3+

Hyaline casts: ☐ None ☐ 1-5 hyaline casts per LPF ☐ Other, describe: _____

Granular casts: ☐ None ☐ 1-5 granular casts per LPF ☐ Other, describe: _____

Blood: ☐ None ☐ Trace blood and no RBCs per HPF ☐ Trace blood and 1-5 RBCs per HPF ☐ 1+ blood and 1-5 RBCs per HPF ☐ 1+ blood and 5-10 RBCs per HPF ☐ 2+ blood and 10-20 RBCs per HPF ☐ Other, describe: _____

D. 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 AUTOIMMUNE DISEASE IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of the veteran's autoimmune disease, 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 NUMBERS | 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.