



## LOSS OF SENSE OF SMELL AND/OR TASTE 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 LOSS OF SENSE OF SMELL OR TASTE? *(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 *(check all that apply)*

- |  |                 |                          |
|--|-----------------|--------------------------|
| <input type="checkbox"/> ANOSMIA <i>(inability to detect any odor)</i>         | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> HYPOSMIA <i>(reduced ability to detect any odors)</i> | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> AGEUSIA <i>(complete lack of taste)</i>               | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> HYPOGEUSIA <i>(decrease in sense of taste)</i>        | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> OTHER <i>(specify)</i>                                |                 |                          |
| Other diagnosis #1 _____   | ICD Code: _____ | Date of diagnosis: _____ |
| Other diagnosis #2 _____   | ICD Code: _____ | Date of diagnosis: _____ |

1C. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO COMPLETE LOSS OF SENSE OF SMELL OR TASTE, 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

3. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S LOSS OF SENSE OF SMELL OR TASTE *(brief summary)*:

### SECTION IV - SYMPTOMS

4A. DOES THE VETERAN CURRENTLY HAVE LOSS OF SENSE OF SMELL?

- YES  NO *(If "Yes," indicate severity)*
- PARTIAL  
 COMPLETE

*(If "Yes," is there a known anatomical or pathological basis for this condition?)*

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

4B. DOES THE VETERAN CURRENTLY HAVE LOSS OF SENSE OF TASTE *(unable to detect sweet, salty, sour, or bitter tastes)?*

- YES  NO *(If "Yes," indicate severity)*
- PARTIAL  
 COMPLETE

*(If "Yes," is there a known anatomical or pathological basis for this condition?)*

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

**SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, 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 testing has been performed and reflects the veteran's current condition, repeat testing is not required. Specific diagnostic testing is not required for a loss of smell and taste examination.

6A. HAVE IMAGING OR LABORATORY STUDIES BEEN PERFORMED?

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

Magnetic resonance imaging (MRI) Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 Computed tomography (CT) Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 Other: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

6B. HAS QUALITATIVE SMELL TESTING BEEN PERFORMED?

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

Type of test: \_\_\_\_\_ 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 - brief summary):

**SECTION VII - FUNCTIONAL IMPACT**

7. DOES THE VETERAN'S LOSS OF SENSE OF SMELL OR TASTE IMPACT ON HIS OR HER ABILITY TO WORK?

YES  NO (If "Yes," describe the impact of each of the veteran's conditions related to the loss of sense of smell or taste, 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](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.