OMB Control No. 2900-0781
Respondent Burden: 15 Minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

THYROID AND PARATHYROID CONDITIONS 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 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 EVER HAD A THYROID OR PARATHYROID CONDITION? *(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):*

☐ HYPERTHYROIDISM	ICD code: _____	Date of diagnosis: _____
☐ TOXIC ADENOMA OF THYROID	ICD code: _____	Date of diagnosis: _____
☐ NON-TOXIC ADENOMA OF THYROID *(euthyroid)*	ICD code: _____	Date of diagnosis: _____
☐ EUTHYROID MULTINODULAR GOITER	ICD code: _____	Date of diagnosis: _____
☐ HYPOTHYROIDISM	ICD code: _____	Date of diagnosis: _____
☐ HYPERPARATHYROIDISM	ICD code: _____	Date of diagnosis: _____
☐ HYPOPARATHYROIDISM	ICD code: _____	Date of diagnosis: _____
☐ C-CELL HYPERPLASIA	ICD code: _____	Date of diagnosis: _____
☐ BENIGN NEOPLASM OF THE THYROID	ICD code: _____	Date of diagnosis: _____
☐ MALIGNANT NEOPLASM OF THE THYROID	ICD code: _____	Date of diagnosis: _____
☐ BENIGN NEOPLASM PARATHYROID	ICD code: _____	Date of diagnosis: _____
☐ MALIGNANT NEOPLASM PARATHYROID	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 THYROID OR PARATHYROID CONDITION(S) 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 THYROID AND/OR PARATHYROID CONDITION(S) *(brief summary):*

3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF A THYROID OR PARATHYROID CONDITION?

☐ YES ☐ NO *(If "Yes," specify the condition(s) and list only those medications required for the condition(s)):*

3C. HAS THE VETERAN HAD RADIOACTIVE IODINE TREATMENT FOR A THYROID CONDITION?

☐ YES ☐ NO *(If "Yes," specify the condition and type of treatment):* _____

(Date of treatment): _____

3D. HAS THE VETERAN HAD SURGERY FOR A THYROID OR PARATHYROID CONDITION?

☐ YES ☐ NO *(If "Yes," specify the condition and type of surgery):* _____

(Date of surgery): _____

3E. HAS THE VETERAN HAD ANY OTHER TYPE OF TREATMENT FOR A THYROID OR PARATHYROID CONDITION?

☐ YES ☐ NO *(If "Yes," specify the condition and type of treatment):* _____

(Date of treatment): _____

SECTION III - MEDICAL HISTORY *(Continued)*

3F. DOES THE VETERAN HAVE ANY RESIDUAL ENDOCRINE DYSFUNCTION FOLLOWING TREATMENT FOR THYROID OR PARATHYROID CONDITION?

☐ YES ☐ NO

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

☐ Hypothyroid endocrine dysfunction ☐ Hypoparathyroid endocrine dysfunction

☐ Other *(Describe):* _____

SECTION IV - FINDINGS, SIGNS AND SYMPTOMS

4A. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO A HYPERTHYROID CONDITION?

☐ YES ☐ NO

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

☐ Tachycardia *(more than 100 beats per minute)*

(If "Yes," indicate frequency of tachycardia):

☐ Constant ☐ Intermittent

☐ Palpitations

☐ Atrial fibrillation or other arrhythmia attributable to a thyroid condition

(If checked, indicate frequency):

☐ Constant ☐ Intermittent *(paroxysmal)*

(If "intermittent," indicate number of episodes in the past 12 months):

☐ 0 ☐ 1-3 ☐ More than 4

(Indicate how these episodes were documented (check all that apply)):

☐ EKG ☐ Holter ☐ Other *(Specify):* _____

☐ Increased pulse pressure or blood pressure

☐ Tremor

☐ Emotional instability

☐ Fatigability

☐ Thyroid enlargement

☐ Eye involvement *(exophthalmos) (If checked, ALSO complete VA Form 21-0960N-2, Eye Conditions Disability Benefits Questionnaire)*

☐ Muscular weakness

☐ Increased sweating

☐ Flushing

☐ Heat Intolerance

☐ Frequent bowel movements

☐ Irregular or absent menstrual periods in women

☐ Weight loss attributable to a hyperthyroid condition

(If checked, provide baseline weight: _____ *and current weight:* _____ *)*

(For VA purposes, baseline weight is the average weight for a 2-year period preceding onset of disease)

☐ Other

(For all checked conditions complete 4B)

4B. DESCRIBE THE CHECKED CONDITION(S):

4C. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO A HYPOTHYROID CONDITION?

☐ YES ☐ NO

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

☐ Fatigability *(If checked, describe):* _____

☐ Constipation

☐ Mental sluggishness

☐ Mental disturbance *(dementia, slowing of thought, depression)*

☐ Muscular weakness

☐ Weight gain

(If checked, provide baseline weight: _____ *and current weight:* _____ *)*

(For VA purposes, baseline weight is the average weight for a 2-year period preceding onset of disease)

☐ Sleepiness

☐ Cold Intolerance

☐ Bradycardia *(less than 60 beats per minute)*

☐ Other

(For all checked conditions complete 4D)

4D. DESCRIBE THE CHECKED CONDITION(S):

SECTION IV - FINDINGS, SIGNS AND SYMPTOMS *(Continued)*

4E. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO A HYPERPARATHYROID CONDITION?

☐ YES ☐ NO

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

☐ Weakness *(If checked, describe):* _____

☐ Kidney stones *(If checked, describe, providing dates and treatment):* _____

☐ Generalized decalcification of bones *(If checked, has the veteran had a bone density test, such as a DEXA scan?)*

☐ YES ☐ NO *(If "Yes," provide date of test* _____ *results:* _____ *)*

☐ Nausea
☐ Vomiting
☐ Constipation
☐ Anorexia
☐ Peptic Ulcer
☐ Weight loss

(If checked, provide baseline weight: _____ *and current weight:* _____ *)*

(For VA purposes, baseline weight is the average weight for a 2-year period preceding onset of disease)

☐ Other

(For all checked conditions complete 4F)

4F. DESCRIBE THE CHECKED CONDITION(S):

4G. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO A HYPOPARATHYROID CONDITION?

☐ YES ☐ NO

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

☐ Paresthesias *(of arms, legs or circumoral area)*
☐ Cataract *(If checked, ALSO complete VA Form 21-0960N-2, Eye Conditions Disability Benefits Questionnaire)*
☐ Evidence of increased intracranial pressure *(such as papilledema)*
☐ Marked neuromuscular excitability
☐ Convulsions
☐ Muscular spasms *(tetany)*
☐ Laryngeal stridor
☐ Other

(For all checked conditions complete 4H)

4H. DESCRIBE THE CHECKED CONDITION(S):

4I. DOES THE VETERAN CURRENTLY HAVE SYMPTOMS DUE TO PRESSURE ON ADJACENT ORGANS SUCH AS THE TRACHEA, LARYNX, OR ESOPHAGUS ATTRIBUTABLE TO A THYROID CONDITION?

☐ YES ☐ NO

(If "Yes," indicate which adjacent organs are affected):

☐ Larynx and/or trachea *(If checked, report pulmonary function testing results in Section X, Diagnostic Testing)*
☐ Esophagus *(If checked, indicate severity of pressure-related symptoms/swallowing difficulty - check all that apply)*

☐ Mild ☐ Moderate ☐ Severe, permitting the passage of liquids only ☐ Causing marked impairment of health

(For all checked conditions complete 4J)

4J. DESCRIBE THE CHECKED CONDITION(S):

SECTION V - PHYSICAL EXAM

5A. EYES:

☐ NORMAL, NO EXOPTHALMOS ☐ ABNORMAL *(If checked, describe):* _____

(If "Abnormal," complete VA Form 21-0960N-2, Eye Conditions Disability Benefits Questionnaire)

5B. NECK:

☐ NORMAL, NO PALPABLE THYROID ENLARGEMENT OR NODULES

☐ ABNORMAL, DIFFUSELY ENLARGED THYROID GLAND

☐ ABNORMAL, ENLARGED THYROID NODULE *(If checked, describe location, size and consistency):* _____

☐ ABNORMAL, WITH DISFIGUREMENT OF THE HEAD OR NECK DUE TO ENLARGEMENT OF THE THYROID GLAND
(If checked, describe by completing Section VII, Scars or other Disfigurement of the Neck)

☐ OTHER *(Describe):* _____

5C. PULSE

☐ REGULAR ☐ IRREGULAR *(Provide heart rate: _____)*

5D. BLOOD PRESSURE

(Provide blood pressure: _____)

SECTION VI - REFLEX EXAM

6. REFLEXES *(Rate deep tendon reflexes (DTRs) according to the following scale):*

0 Absent
1+ Hypoactive
2+ Normal
3+ Hyperactive without clonus
4+ Hyperactive with clonus

☐ ALL NORMAL

BICEPS:						KNEE:				
Right	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+	Right	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Left	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+	Left	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
TRICEPS:						ANKLE:				
Right	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+	Right	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Left	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+	Left	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
BRACHIORADIALIS:										
Right	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+					
Left	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+					

SECTION VII - SCARS OR OTHER DISFIGUREMENT OF THE NECK

7A. DOES THE VETERAN HAVE ANY SCARS OR OTHER DISFIGUREMENT OF THE NECK RELATED TO TREATMENT FOR ANY THYROID OR PARATHYROID CONDITION?

☐ YES ☐ NO

(If "Yes," complete the following):

1.Total number of unstable or painful scars: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

2. Is any scar 13 cm in length or longer?

☐ YES ☐ NO

3. Is any scar 0.6 cm in width or wider?

☐ YES ☐ NO

4. Is any scar elevated or depressed?

☐ YES ☐ NO

5. Is any scar adherent to underlying tissue?

☐ YES ☐ NO

7B. DOES THE VETERAN HAVE ANY AREAS OF SKIN OF THE NECK THAT ARE HYPO- OR HYPERPIGMENTED, THAT HAVE ABNORMAL TEXTURE, THAT HAVE MISSING UNDERLYING SOFT TISSUE, OR THAT ARE INDURATED AND INFLEXIBLE RELATED TO THYROID OR PARATHYROID DISEASE OR THEIR TREATMENT?

☐ YES ☐ NO

(If "Yes," complete the following):

1. Approximate total area of skin with hypo- or hyperpigmentation: _____ cm2

2. Approximate total area of skin with abnormal texture: _____ cm2

3. Approximate total area of skin with missing underlying soft tissue: _____ cm2

4. Approximate total area of skin that is indurated and inflexible: _____ cm2

SECTION VIII - TUMORS AND NEOPLASMS

8A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO *(If "Yes," complete Items 8B thru 8E)*

8B. IS THE NEOPLASM

☐ BENIGN ☐ MALIGNANT

8C. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

☐ YES ☐ NO; WATCHFUL WAITING

(If "Yes," indicate type of treatment the veteran is currently undergoing or has completed - check all that apply):

☐ Treatment completed; currently in watchful waiting status

☐ 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):* _____

☐ Antineoplastic chemotherapy

(Date of most recent treatment): _____ *(Date of completion of treatment or anticipated date of completion):* _____

☐ Other therapeutic procedure (*If checked, describe procedure):* _____

(Date of most recent procedure): _____

☐ Other therapeutic treatment (*If checked, describe treatment):* _____

(Date of completion of treatment or anticipated date of completion): _____

8D. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM *(including metastases)* OR ITS TREATMENT OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT IN ITEM 8C?

☐ YES ☐ NO *(If "Yes," list residual conditions and complications - brief summary):*

8E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS, DESCRIBE USING THE FORMAT IN ITEM 8C:

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

9. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY OF THE CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

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

SECTION X - DIAGNOSTIC TESTING

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

10A. HAVE IMAGING STUDIES BEEN PERFORMED?

☐ YES ☐ NO

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

☐ Magnetic resonance imaging *(MRI)*	Date: _____	Results: _____
☐ Computed tomography *(CT)*	Date: _____	Results: _____
☐ Thyroid scan	Date: _____	Results: _____
☐ Thyroid ultrasound	Date: _____	Results: _____
☐ Other: _____	Date: _____	Results: _____

10B. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO *(If "Yes," check all that apply and provide date of most recent test and results):*

☐ TSH	Date: _____	Results: _____
☐ Free T4	Date: _____	Results: _____
☐ Free T3	Date: _____	Results: _____
☐ Thyroid antibodies	Date: _____	Results: _____
☐ Parathyroid hormone *(PTH)*	Date: _____	Results: _____
☐ Calcium	Date: _____	Results: _____
☐ Ionized calcium	Date: _____	Results: _____
☐ Other: _____	Date: _____	Results: _____

SECTION X - DIAGNOSTIC TESTING *(Continued)*

10C. HAVE PULMONARY FUNCTION TESTS (PFTs) BEEN PERFORMED?

(For VA purposes, PFTs should be performed if there is pressure on the larynx or trachea attributable to a thyroid condition)

☐ YES ☐ NO

(If "Yes," provide most recent results, if available):

FEV-1: _____ % predicted Date: _____

FEV-1/FVC: _____ % Date: _____

FVC : _____ % predicted Date: _____

IS FLOW-VOLUME LOOP COMPATIBLE WITH UPPER AIRWAY OBSTRUCTION?

☐ YES ☐ NO

10D. HAS A BIOPSY BEEN PERFORMED?

☐ YES ☐ NO

Site of biopsy: _____ Date of test: _____ Results: _____

10E. 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 XI - FUNCTIONAL IMPACT

11. DOES THE VETERAN'S THYROID OR PARATHYROID CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If Yes," describe impact of the veteran's thyroid and/or parathyroid condition, providing one or more examples):*

SECTION XII - REMARKS

12. REMARKS *(If any):*

SECTION XIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

13A. PHYSICIAN'S SIGNATURE	13B. PHYSICIAN'S PRINTED NAME	13C. DATE SIGNED

13D. PHYSICIAN'S PHONE AND FAX NUMBERS	13E. PHYSICIAN'S MEDICAL LICENSE NUMBER	13F. 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.