OMB Control No. 2900-0778
Respondent Burden: 15 Minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

ESOPHAGEAL CONDITIONS (Including gastroesophageal reflux disease (GERD), hiatal hernia and other esophageal disorders) 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

NOTE: The diagnosis of gastroesophageal reflux disease (GERD) can be made clinically by evidence of relief of typical symptoms of reflux, epigastric discomfort and/or burning, by treatment with proton pump inhibitors, histamine 2 receptor antagonists and/or antacids. If upper endoscopy was indicated or performed, the findings of erythema, ulcers and/or strictures are consistent with the diagnosis of GERD.

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN ESOPHAGEAL CONDITION?

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

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed below. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in the Remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date is determined through record review or reported history.

1B. DIAGNOSIS *(Check all that apply)*

☐ GERD	ICD CODE:		DATE OF DIAGNOSIS:	
☐ HIATAL HERNIA	ICD CODE:		DATE OF DIAGNOSIS:	
☐ ESOPHAGEAL STRICTURE	ICD CODE:		DATE OF DIAGNOSIS:	
☐ ESOPHAGEAL SPASM	ICD CODE:		DATE OF DIAGNOSIS:	
☐ ESOPHAGEAL DIVERTICULUM	ICD CODE:		DATE OF DIAGNOSIS:	
☐ OTHER ESOPHAGEAL CONDITION(S), specify: *(such as eosinophilic esophagitis, Barrett's esophagitis, etc.)*				
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 ESOPHAGEAL DISORDERS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S ESOPHAGEAL CONDITIONS *(brief summary)*:

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITION?

☐ YES ☐ NO *(If, "Yes," list only those medications used for the diagnosed condition):*

SECTION III - SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR SYMPTOMS DUE TO ANY ESOPHAGEAL CONDITIONS *(including GERD)*?

☐ YES ☐ NO

(If "Yes," check all that apply)

☐ PERSISTENTLY RECURRENT EPIGASTRIC DISTRESS
If checked, indicate frequency of symptom recurrence per year:
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
If checked, indicate average duration of episodes of symptoms:
☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ INFREQUENT EPISODES OF EPIGASTRIC DISTRESS
If checked, indicate frequency of symptom recurrence per year:
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
If checked, indicate average duration of episodes of symptoms:
☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ DYSPHAGIA
If checked, indicate frequency of symptom recurrence per year:
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
If checked, indicate average duration of episodes of symptoms:
☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ PYROSIS *(Heartburn)*
If checked, indicate frequency of symptom recurrence per year:
☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
If checked, indicate average duration of episodes of symptoms:
☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

SECTION III - SIGNS AND SYMPTOMS *(Continued)*

☐ REFLUX

If checked, indicate frequency of symptom recurrence per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of symptoms:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ REGURGITATION

If checked, indicate frequency of symptom recurrence per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of symptoms:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ SUBSTERNAL ARM OR SHOULDER PAIN

If checked, indicate frequency of symptom recurrence per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of symptoms:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ SLEEP DISTURBANCE CAUSE BY ESOPHAGEAL REFLUX

If checked, indicate frequency of symptom recurrence per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of symptoms:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ ANEMIA

If checked, provide hemoglobin/hematocrit in diagnostic testing section.

☐ WEIGHT LOSS

If checked, provide baseline weight: _____ and current weight: _____

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

☐ NAUSEA

If checked, indicate severity:

☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic

If checked, indicate frequency of episodes of nausea per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of nausea:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ VOMITING

If checked, indicate severity:

☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic

If checked, indicate frequency of episodes of vomiting per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of vomiting:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ HEMATEMESIS

If checked, indicate severity:

☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic

If checked, indicate frequency of episodes of vomiting per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of vomiting:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ MELENA

If checked, indicate severity:

☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic

If checked, indicate frequency of episodes of vomiting per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of vomiting:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

SECTION IV - ESOPHAGEAL STRICTURE, SPASM AND DIVERTICULA

4. DOES THE VETERAN HAVE AN ESOPHAGEAL STRICTURE, SPASM OF ESOPHAGUS (CARDIOSPASM OR ACHALASIA), OR AN ACQUIRED DIVERTICULUM OF THE ESOPHAGUS?

☐ YES ☐ NO

If Yes, indicate severity of condition:

☐ ASYMPTOMATIC

☐ NOT AMENABLE TO DILATION

☐ MILD If checked, describe: _____

☐ MODERATE If checked, describe: _____

☐ SEVERE, PERMITTING PASSAGE OF LIQUIDS ONLY If checked, describe: _____

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

5A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS? IF YES, DESCRIBE *(brief summary)*:

5B. DOES THE VETERAN HAVE ANY SCARS (SURGICAL OR OTHERWISE) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO

IF YES, ARE ANY OF THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM (6 square inches); OR ARE LOCATED ON THE HEAD, FACE OR NECK?

☐ YES ☐ NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT DISABILITY BENEFITS QUESTIONNAIRE.

IF NO, PROVIDE LOCATION AND MEASURMENTS OF SCAR IN CENTIMETERS

LOCATION: _____

MEASUREMENTS: Length _____ cm X width _____ cm.

NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in the Remarks section below. It is not necessary to also complete a Scars DBQ.

SECTION VI - DIAGNOSTIC TESTING

Note: If testing has been performed and reflects veteran's current condition, no further testing is required for this examination report.

6A. HAVE DIAGNOSTIC IMAGING STUDIES OR OTHER DIAGNOSTIC PROCEDURES BEEN PERFORMED?

☐ YES ☐ NO

If Yes, check all that apply:

☐ UPPER ENDOSCOPY

Date: _____ Results: _____

☐ UPPER GI RADIOGRAPHIC STUDIES

Date: _____ Results: _____

☐ ESOPHAGRAM *(barium swallow)*

Date: _____ Results: _____

☐ MRI

Date: _____ Results: _____

☐ CT

Date: _____ Results: _____

☐ BIOPSY, SPECIFY SITE:

Date: _____ Results: _____

☐ OTHER, SPECIFY:

Date: _____ Results: _____

SECTION VI - DIAGNOSTIC TESTING *(Continued)*

6B. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO

If Yes, check all that apply:

☐ CBC Date of testing: _____

Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____

☐ HELICOBACTER PYLORI Date of test: _____ Results: _____

☐ OTHER, SPECIFY: _____ Date of test: _____ 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. DO ANY OF THE VETERAN"S ESOPHAGEAL CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

If Yes, describe impact of each of the veteran's esophageal conditions, providing one ore 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 NUMBER	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** 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.