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

Department of Veterans Affairs

STOMACH AND DUODENAL CONDITIONS (NOT INCLUDING GERD OR 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 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 HAD ANY STOMACH OR DUODENUM CONDITIONS?

☐ 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. SELECT THE VETERAN'S CONDITION *(check all that apply):*

☐ GASTRIC ULCER	ICD code: _____	Date of diagnosis: _____
☐ DUODENAL ULCER	ICD code: _____	Date of diagnosis: _____
☐ STENOSIS OF THE STOMACH	ICD code: _____	Date of diagnosis: _____
☐ MARGINAL (GASTROJEJUNAL) ULCER	ICD code: _____	Date of diagnosis: _____
☐ HYPERTROPHIC GASTRITIS	ICD code: _____	Date of diagnosis: _____
☐ POSTGASTRECTOMY SYNDROME	ICD code: _____	Date of diagnosis: _____
☐ STATUS POST VAGOTOMY WITH PYLOROPLASTY	ICD code: _____	Date of diagnosis: _____
☐ GASTROENTEROSTOMY	ICD code: _____	Date of diagnosis: _____
☐ PERITONEAL ADHESIONS FOLLOWING INJURY OR SURGERY OF THE STOMACH	ICD code: _____	Date of diagnosis: _____
☐ HELICOBACTER PYLORI	ICD code: _____	Date of diagnosis: _____

☐ OTHER STOMACH OR DUODENAL CONDITIONS

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 STOMACH OR DUODENUM CONDITIONS, LIST USING ABOVE FORMAT:

NOTE: The diagnosis of gastric or duodenal ulcer or stenosis can be made by upper gastrointestinal imaging series or endoscopy. The diagnosis of gastritis requires endoscopic confirmation. If testing is of record and is consistent with veteran's current condition, repeat testing is not required.

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S STOMACH OR DUODENUM 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 STOMACH OR DUODENUM CONDITIONS?

☐ YES ☐ NO

IF YES, *(check all that apply)*:

☐ Recurring episodes of symptoms that are not severe

If checked, indicate frequency of episodes of symptom recurrence per year:

☐ 0 ☐ 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

☐ Recurring episodes of severe symptoms

If checked, indicate frequency of episodes of symptom recurrence per year:

☐ 0 ☐ 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

☐ Abdominal Pain

If checked, indicate severity and frequency *(check all that apply)*:

SEVERITY: ☐ Relieved by standard ulcer therapy ☐ Only partially relieved by standard ulcer therapy ☐ Unrelieved by standard ulcer therapy

FREQUENCY: ☐ Occurs less than monthly ☐ Occurs at least monthly ☐ Pronounced ☐ Periodic ☐ Continuous

☐ 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:

☐ 0 ☐ 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:

☐ 0 ☐ 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 hematemesis per year:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of hematemesis:

☐ 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 melena per year:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of melena:

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

SECTION IV - INCAPACITATING EPISODES

4. DOES THE VETERAN HAVE INCAPACITATING EPISODES DUE TO SIGNS OR SYMPTOMS OF ANY STOMACH OR DUODENUM CONDITION?

☐ YES ☐ NO

IF YES, DESCRIBE INCAPACITATING EPISODES: _____

Indicate frequency of incapacitating episodes per year:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Indicate average duration of incapacitating episodes:

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

SECTION V - OTHER CONDITIONS

5. DOES THE VETERAN HAVE ANY OF THE FOLLOWING CONDITIONS?

☐ YES ☐ NO

IF YES, INDICATE CONDITIONS AND COMPLETE APPROPRIATE SECTIONS *(check all that apply)*:

☐ Hypertrophic gastritis

If checked, indicate severity:

- ☐ No symptoms or findings
- ☐ Chronic, with small nodular lesions, and symptoms
- ☐ Chronic, with multiple small eroded or ulcerated areas, and symptoms
- ☐ Chronic, with severe hemorrhages, or large ulcerated or eroded areas

NOTE: If atrophic gastritis is present, state the underlying cause: _____

☐ Postgastrectomy syndrome

If checked, indicate severity:

- ☐ No symptoms or findings
- ☐ Mild; infrequent episodes of epigastric distress with characteristic mild circulatory symptoms or continuous mild manifestations.
- ☐ Moderate; less frequent episodes of epigastric disorders with characteristic mild circulatory symptoms after meals but with diarrhea and weight loss
- ☐ Severe; associated with nausea, sweating, circulatory disturbance after meals, diarrhea, hypoglycemic symptoms, and weight loss with malnutrition and anemia

☐ Vagotomy with pyloroplasty or gastroenterostomy

If checked, indicate the severity of residuals following vagotomy with pyloroplasty or gastroenterostomy:

- ☐ No symptoms or findings
- ☐ Recurrent ulcer with incomplete vagotomy
- ☐ Symptoms and confirmed diagnosis of alkaline gastritis, or of confirmed persisting diarrhea
- ☐ Demonstrably confirmative postoperative complications of stricture or continuing gastric retention

☐ Peritoneal adhesions following an injury or surgical procedure of the stomach or duodenum

If checked, ALSO complete the VA Form 21-0960G-6, Peritoneal Adhesions Disability Benefits Questionnaire.

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 THE DIAGNOSIS SECTION?

☐ 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 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.

6B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO IF YES, DESCRIBE *(brief summary):*

SECTION VII - DIAGNOSTIC TESTING

NOTE: If testing has been performed and reflects veteran's current condition, no further testing is required for this examination report.
The diagnosis of gastric or duodenal ulcer or stenosis can be made by upper gastrointestinal imaging series or endoscopy.

7A. 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: _____

☐ MRI Date: _____ Results: _____

☐ CT Date: _____ Results: _____

☐ Biopsy, specify site: _____ Date: _____ Results: _____

☐ Other, specify: _____ Date: _____ Results: _____

7B. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐ CBC Date of test: _____

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

☐ Helicobacter pylori Date of test: _____ Results: _____

☐ Other, specify: _____ Date of test: _____ Results: _____

7C. 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. DO ANY OF THE VETERAN'S STOMACH OR DUODENUM CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

IF YES, DESCRIBE IMPACT OF EACH OF THE VETERAN'S STOMACH OR DUODENUM CONDITIONS, 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** 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, 58VA21/22/28, 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 a 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.