



### 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)*

**NOTE:** These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. 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 appropriate date determined through record review or reported history.

1B. SELECT THE VETERAN'S CONDITION *(Check all that apply):*

- |  |                 |                          |
|--|-----------------|--------------------------|
| <input type="checkbox"/> HYPERTHYROIDISM                                 | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> TOXIC ADENOMA OF THYROID                        | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> NON-TOXIC ADENOMA OF THYROID <i>(euthyroid)</i> | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> EUTHYROID MULTINODULAR GOITER                   | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> HYPOTHYROIDISM                                  | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> HYPERPARATHYROIDISM                             | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> HYPOPARATHYROIDISM                              | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> C-CELL HYPERPLASIA                              | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> BENIGN NEOPLASM OF THE THYROID                  | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> MALIGNANT NEOPLASM OF THE THYROID               | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> BENIGN NEOPLASM PARATHYROID                     | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> MALIGNANT NEOPLASM PARATHYROID                  | 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 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  1-4  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

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
- 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 EXOPHTHALMOS     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:

Right  0     1+     2+     3+     4+  
Left  0     1+     2+     3+     4+

KNEE:

Right  0     1+     2+     3+     4+  
Left  0     1+     2+     3+     4+

TRICEPS:

Right  0     1+     2+     3+     4+  
Left  0     1+     2+     3+     4+

ANKLE:

Right  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: \_\_\_\_\_ cm<sup>2</sup>
2. Approximate total area of skin with abnormal texture: \_\_\_\_\_ cm<sup>2</sup>
3. Approximate total area of skin with missing underlying soft tissue: \_\_\_\_\_ cm<sup>2</sup>
4. Approximate total area of skin that is indurated and inflexible: \_\_\_\_\_ cm<sup>2</sup>

**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?

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):

- |   |             |                |
|---|-------------|----------------|
| <input type="checkbox"/> Magnetic resonance imaging (MRI) | Date: _____ | Results: _____ |
| <input type="checkbox"/> Computed tomography (CT)         | Date: _____ | Results: _____ |
| <input type="checkbox"/> Thyroid scan                     | Date: _____ | Results: _____ |
| <input type="checkbox"/> Thyroid ultrasound               | Date: _____ | Results: _____ |
| <input type="checkbox"/> 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):

- |  |             |                |
|--|-------------|----------------|
| <input type="checkbox"/> TSH                       | Date: _____ | Results: _____ |
| <input type="checkbox"/> Free T4                   | Date: _____ | Results: _____ |
| <input type="checkbox"/> Free T3                   | Date: _____ | Results: _____ |
| <input type="checkbox"/> Thyroid antibodies        | Date: _____ | Results: _____ |
| <input type="checkbox"/> Parathyroid hormone (PTH) | Date: _____ | Results: _____ |
| <input type="checkbox"/> Calcium                   | Date: _____ | Results: _____ |
| <input type="checkbox"/> Ionized calcium           | Date: _____ | Results: _____ |
| <input type="checkbox"/> 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](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.