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

Department of Veterans Affairs

HIV - RELATED ILLNESSES 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/SHE EVER BEEN DIAGNOSED WITH AN HIV-RELATED ILLNESS?

☐ YES ☐ NO *(If "Yes," complete Item1B)*

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. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO HIV-RELATED ILLNESSES OR COMPLICATIONS:

Diagnosis # 1 -	ICD code -	Date of diagnosis-
Diagnosis # 2 -	ICD code -	Date of diagnosis-
Diagnosis # 3 -	ICD code -	Date of diagnosis-

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO HIV-RELATED ILLNESS, 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 HIV-RELATED ILLNESS(ES) *(brief summary)*:

3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF HIV-RELATED ILLNESS(ES)?

☐ YES ☐ NO *(If "Yes," list only those medications required for the veteran's HIV-related illness(es)) (If the veteran has more than one HIV-related illness(es), specify the condition for which each medication is required)*

3C. DOES THE VETERAN HAVE ANY COMPLICATIONS DUE TO CURRENT OR PREVIOUS MEDICATIONS TAKEN FOR HIV-RELATED ILLNESS(ES)?

☐ YES ☐ NO *(If "Yes," list medication and describe complication(s) due to medication(s)):*

SECTION IV - SIGNS, SYMPTOMS AND FINDINGS

4. DOES THE VETERAN HAVE ANY SIGNS, SYMPTOMS OR FINDINGS ATTRIBUTABLE TO AN HIV-RELATED ILLNESS?

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

☐ A. CONSTITUTIONAL SYMPTOMS *(fever, weight loss, fatigue, malaise, decreased appetite, etc.)* ATTRIBUTABLE TO AN HIV-RELATED ILLNESS

(If checked, indicate frequency and severity):

☐ Refractory ☐ Recurrent

(Describe constitutional symptoms): _____

☐ B. DIARRHEA ATTRIBUTABLE TO AN HIV-RELATED ILLNESS.

(If checked, indicate frequency and severity):

☐ Refractory ☐ Intermittent

(Describe): _____

☐ C. WEIGHT LOSS ATTRIBUTABLE TO AN HIV-RELATED ILLNESS

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

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

☐ D. NAUSEA ATTRIBUTABLE TO AN HIV-RELATED ILLNESS

(If checked, indicate severity):

☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic

(Indicate frequency of episodes of nausea per year)

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

☐ E. VOMITING ATTRIBUTABLE TO AN HIV-RELATED ILLNESS

(If checked, indicate severity):

☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic

(Indicate frequency of episodes of vomiting per year)

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

(Indicate average duration of episodes of vomiting)

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

☐ F. ANEMIA OF CHRONIC DISEASE ATTRIBUTABLE TO AN HIV-RELATED ILLNESS

(If checked, describe): _____

(Provide hemoglovin/hematocrit in Section 10, Diagnostic Testing)

☐ G. HAIRY CELL LEUKOPLAKIA

(If checked, is veteran currently affected by hairy cell leukoplakia?)

☐ Yes ☐ No

(Provide date(s) of onset, treatment and course): _____

☐ H. ORAL CANDIDIASIS

(If checked, is veteran currently affected by oral candidiasis?)

☐ Yes ☐ No

(Provide date(s) of onset, treatment and course): _____

☐ I. OTHER *(Describe):*

SECTION V - COMPLICATIONS

5A. DOES THE VETERAN HAVE ANY COMPLICATIONS ATTRIBUTABLE TO AN HIV-RELATED ILLNESS?

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

- ☐ HIV-associated neuropathy, radiculopathy or myelopathy *(If checked, ALSO complete VA Form 21-0960C-10, Peripheral Nerves Disability Benefits Questionnaire)*
- ☐ HIV-associated retinopathy *(If checked, ALSO complete VA Form 21-0960N-2, Eye Conditions Disability Benefits Questionnaire)*
- ☐ HIV-associated cardiopathy *(If checked, ALSO complete VA Form 21-0960A-4, Heart Disease (including arrhythmias and surgery) Disability Benefits Questionnaire)*
- ☐ HIV-associated pulmonary hypertension *(If checked, ALSO complete VA Form 21-0960L-1, Respiratory Conditions Disability Benefits Questionnaire)*
- ☐ HIV-associated enteropathy *(If checked, ALSO complete VA Form 21-0960G-3, Intestinal Conditions (other than surgical or infectious) Disability Benefits Questionnaire or VA Form 21-0960G-4, Intestinal Conditions (surgical or infectious) Disability Benefits Questionnaire)*
- ☐ HIV-associated nephropathy *(If checked, ALSO complete VA Form 21-0960J-1, Kidney Conditions Disability Benefits Questionnaire)*
- ☐ HIV-associated impaired lipid and glucose metabolism
- ☐ HIV-associated wasting
- ☐ Lipodystrophy
- ☐ Myopathy
- ☐ Other, describe: _____

5B. FOR EACH CHECKED CONDITION IN ITEM 5A, *(except those for which an additional DBQ is completed)* DESCRIBE *(providing date of onset, and a brief summary of symptoms, treatment and course).*

SECTION VI - INFECTIOUS AND ONCOLOGIC COMPLICATIONS

6A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER HAD ANY HIV-RELATED OPPORTUNISTIC INFECTIOUS OR ONCOLOGIC CONDITIONS?

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

- ☐ Oral candidiasis
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Pneumocystosis
- ☐ Toxoplasmosis
- ☐ Cryptococcosis
- ☐ Cerebral toxoplasmosis
- ☐ Cryptococcal meningoencephalitis
- ☐ Viral meningoencephalitis
- ☐ Cytomegalovirus
- ☐ Herpes simplex virus
- ☐ Varicella zoster virus
- ☐ Progressive multifocal leukoencephalopathy
- ☐ Neurosyphilis
- ☐ Primary central nervous system lymphoma
- ☐ Other, describe: _____

6B. FOR EACH CHECKED CONDITION IN ITEM 6A, *(except those for which an additional DBQ is completed)*, DESCRIBE *(providing date of onset, and brief summary of symptoms, treatment and course):*

6C. DOES THE VETERAN HAVE RECURRENT OPPORTUNISTIC INFECTION(S)?

☐ YES ☐ NO *(If "Yes," provide type of infection(s), date(s) of first onset, date(s) of recurrences, treatment and course (brief summary)):*
(NOTE : ALSO complete the appropriate questionnaire for each recurrent opportunistic infection)

SECTION VII - MENTAL HEALTH MANIFESTATIONS DUE TO HIV-RELATED ILLNESS OR ITS TREATMENT

7A. DOES THE VETERAN HAVE DEPRESSION, HIV-ASSOCIATED NEUROCOGNITIVE DISORDER, DEMENTIA, OR ANY OTHER MENTAL HEALTH CONDITIONS ATTRIBUTABLE TO HIV-RELATED ILLNESS OR ITS TREATMENT?

☐ YES ☐ NO

7B. DOES THE VETERAN'S MENTAL HEALTH CONDITION(S), RESULT IN GROSS IMPAIRMENT IN THOUGHT PROCESSES OR COMMUNICATION *(such that an interview with the veteran would not yield useful information)?*

☐ YES ☐ NO *(If "No," ALSO complete VA Form 21-0960P-2, Mental Health Disorders (other than PTSD) Disability Benefits Questionnaire)*

(If "Yes," briefly describe the veteran's mental health condition):

SECTION VIII - SUMMARY

8. BASED ON SYMPTOMS AND FINDINGS FROM THIS EXAM, COMPLETE THE FOLLOWING, ITEMS 8A THRU 8E TO PROVIDE A SUMMARY OF THE SEVERITY OF THE VETERAN'S HIV-RELATED CONDITION *(NOTE: This summary provides useful information for VA purposes)*

(Check all that apply from each level):

A. LEVEL I

☐ Asymptomatic, with or without lymphadenopathy or decreased T4 cell count

B. LEVEL II

☐ Symptomatic, with current T4 cell of 200 or more and less than 500, and on approved medication(s)
(For VA purposes, approved medications include medications prescribed as part of a research protocol at an accredited medical institution)

☐ Evidence of depression with employment limitations

☐ Evidence of memory loss with employment limitations

C. LEVEL III

☐ Recurrent constitutional symptoms, intermittent diarrhea, and on approved medications

☐ Current T4 cell count less than 200

☐ Hairy cell leukoplakia

☐ Oral candidiasis

D. LEVEL IV

☐ Refractory constitutional symptoms

☐ Diarrhea and pathological weight loss

☐ Development of AIDS-related opportunistic infection or neoplasm

E. LEVEL V

☐ AIDS with recurrent opportunistic infections

☐ Secondary diseases afflicting multiple body systems

☐ HIV-related illness with debility and progressive weight loss, without remission or few or brief remissions

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

9A. 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 AND/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 (DBQ).*

IF "NO," PROVIDE LOCATION AND MEASUREMENTS 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. It is not necessary to also complete a Scars/Disfigurement DBQ.

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

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

SECTION X - DIAGNOSTIC TESTING

NOTE - If testing has been performed and reflects the veteran's current condition, repeat testing is not required.

10A. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO

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

CD4 (T4 cell) lymphocyte count: _____ Date: _____

Lowest (nadir) CD4 (T4 cell) lymphocyte count, if available: _____ Date; if know: _____

CBC (if anemia of chronic disease attributable to HIV-related illness is suspected or present):

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

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

10B. HAVE IMAGING STUDIES OR DIAGNOSTIC PROCEDURES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO *(If "Yes," provide type of test or procedure, date and results (brief summary)):*

10C. HAS A HIV DEMENTIA SCALE BEEN ADMINISTERED *(If indicated)*?

☐ YES ☐ NO *(If "Yes," provide results and date)*

Results: Date:

10D. HAS NEUROPSYCHIATRIC TESTING BEEN PERFORMED FOR COGNITIVE IMPAIRMENT *(If indicated)*?

☐ YES ☐ NO *(If "Yes," provide results and date)*

Results: Date:

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. DO ANY OF THE VETERAN'S HIV-RELATED ILLNESSES OR COMPLICATIONS IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact of each of the veteran's HIV-related illness(es), providing one or more examples)*

SECTION XII - REMARKS

12. REMARKS *(If any)*

SECTION XII - 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.