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Department of Veterans Affairs

SINUSITIS/RHINITIS AND OTHER CONDITIONS OF THE NOSE, THROAT, LARYNX AND PHARYNX 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 BEEN DIAGNOSED WITH A SINUS, NOSE, THROAT, LARYNX OR PHARYNX 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)*

☐ CHRONIC SINUSITIS	ICD Code: _____	Date of diagnosis: _____
☐ ALLERGIC RHINITIS	ICD Code: _____	Date of diagnosis: _____
☐ NON-ALLERGIC RHINITIS	ICD Code: _____	Date of diagnosis: _____
☐ BACTERIAL RHINITIS	ICD Code: _____	Date of diagnosis: _____
☐ GRANULOMATOUS RHINITIS	ICD Code: _____	Date of diagnosis: _____
☐ CHRONIC LARYNGITIS	ICD Code: _____	Date of diagnosis: _____
☐ LARYNGECTOMY	ICD Code: _____	Date of diagnosis: _____
☐ LARYNGEAL STENOSIS	ICD Code: _____	Date of diagnosis: _____
☐ APHONIA	ICD Code: _____	Date of diagnosis: _____
☐ DEVIATED NASAL SEPTUM *(Traumatic)*	ICD Code: _____	Date of diagnosis: _____
☐ PHARYNGEAL INJURY *(Describe):* _____ _____	ICD Code: _____	Date of diagnosis: _____
☐ BENIGN OR MALIGNANT NEOPLASM OF SINUS, NOSE, THROAT, LARYNX OR PHARYNX	ICD Code: _____	Date of diagnosis: _____
☐ ANATOMICAL LOSS OF PART OF NOSE *(Complete VA Form 21-0960F-1, Scars/ Disfigurement Disability Benefits Questionnaire in lieu of this questionnaire)*	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 THE SINUSES, NOSE, THROAT, LARYNX, OR PHARYNX 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 SINUS, NOSE, THROAT, LARYNX, OR PHARYNX CONDITION:

3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S SINUS, NOSE, THROAT, LARYNX, OR PHARYNX CONDITION?

☐ YES ☐ NO *(If "Yes," list only those medications required for the veteran's sinus, nose, throat, larynx, or pharynx condition):*

SECTION IV - NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS

4. DOES THE VETERAN HAVE ANY OF THE FOLLOWING NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS?

☐ YES ☐ NO *(If "No," proceed to Section V) (If "Yes," check all that apply):*

- ☐ Sinusitis *(If checked, complete Part A below)*
- ☐ Rhinitis *(If checked, complete Part B below)*
- ☐ Larynx or pharynx condition *(If checked, complete Part C below)*
- ☐ Deviated nasal septum *(traumatic)* *(If checked, complete Part D below)*
- ☐ Tumors or neoplasms *(If checked, complete Part E below)*
- ☐ Other pertinent physical findings or scars due to nose, throat, larynx or pharynx conditions *(If checked, complete Part F below)*

PART A - SINUSITIS

A1. INDICATE THE SINUSES/TYPE OF SINUSITIS CURRENTLY AFFECTED BY THE VETERAN'S CHRONIC SINUSITIS *(Check all that apply):*

☐ NONE ☐ MAXILLARY ☐ FRONTAL ☐ ETHMOID ☐ SPHENOID ☐ PANSINUSITIS

A2. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO CHRONIC SINUSITIS?

☐ YES ☐ NO

(If "Yes," check all that apply)

- ☐ Chronic sinusitis detected only by imaging studies *(See Section V, Diagnostic Testing)*
- ☐ Episodes of sinusitis
- ☐ Near constant sinusitis *(If checked, describe frequency):* _____
- ☐ Headaches
- ☐ Pain and tenderness of affected sinus
- ☐ Purulent discharge or crusting
- ☐ Other *(describe):* _____

FOR ALL CHECKED CONDITIONS, DESCRIBE:

A3. HAS THE VETERAN HAD **NON-INCAPACITATING** EPISODES OF SINUSITIS CHARACTERIZED BY HEADACHES, PAIN AND PURULENT DISCHARGE OR CRUSTING IN THE PAST 12 MONTHS?

☐ YES ☐ NO

(If "Yes," provide the total number of non-incapacitating episodes over the past 12 months):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 7 or more

A4. HAS THE VETERAN HAD **INCAPACITATING** EPISODES OF SINUSITIS REQUIRING PROLONGED *(4 to 6 weeks)* OF ANTIBIOTICS TREATMENT IN THE PAST 12 MONTHS?

NOTE - For VA purposes, an incapacitating episode of sinusitis means one that requires bed rest and treatment prescribed by a physician.

☐ YES ☐ NO

(If "Yes," provide the total number of incapacitating episodes of sinusitis requiring prolonged (4 to 6 weeks) of antibiotic treatment over the past 12 months):

☐ 1 ☐ 2 ☐ 3 or more

A5. HAS THE VETERAN HAD SINUS SURGERY?

☐ YES ☐ NO

(If "Yes," specify type of surgery):

☐ Radical *(open sinus surgery)* ☐ Endoscopic ☐ Other: _____

(Type of procedure, sinuses operated on and side(s)): _____

(Date(s) of surgery (if repeated sinus surgery, provide all dates of surgery)): _____

A6. IF VETERAN HAS HAD RADICAL SINUS SURGERY, DID CHRONIC OSTEOMYELITIS FOLLOW THE SURGERY?

☐ YES ☐ NO *(If "Yes," complete VA Form 21-0960M-11, Osteomyelitis Disability Benefits Questionnaire)*

PART B - RHINITIS

B1. IS THERE GREATER THAN 50% OBSTRUCTION OF THE NASAL PASSAGE ON BOTH SIDES DUE TO RHINITIS?

☐ YES ☐ NO

B2. IS THERE COMPLETE OBSTRUCTION ON ONE SIDE DUE TO RHINITIS?

☐ YES ☐ NO

B3. IS THERE PERMANENT HYPERTROPHY OF THE NASAL TURBINATES?

☐ YES ☐ NO

B4. ARE THERE NASAL POLYPS?

☐ YES ☐ NO

SECTION IV - NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS *(Continued)*

PART B - RHINITIS *(Continued)*

B5. DOES THE VETERAN HAVE ANY OF THE FOLLOWING GRANULOMATOUS CONDITIONS?

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

☐ Granulomatous rhinitis ☐ Rhinoscleroma ☐ Wegener's granulomatosis ☐ Lethal midline granuloma

☐ Other granulomatous infection *(Describe):* _____

PART C - LARYNX AND PHARYNX CONDITIONS

C1. DOES THE VETERAN HAVE CHRONIC LARYNGITIS?

☐ YES ☐ NO

(If "Yes," does the veteran have any of the following symptoms due to chronic laryngitis?)

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

☐ Hoarseness *(If checked, describe frequency):* _____

☐ Inflammation of vocal cords or mucous membrane

☐ Thickening or nodules of vocal chords

☐ Submucous infiltration of vocal chords

☐ Vocal chord polyps

☐ Other *(describe):* _____

C2. HAS THE VETERAN HAD A LARYNGECTOMY?

☐ YES ☐ NO *(If "Yes," specify)*

☐ Total laryngectomy

☐ Partial laryngectomy

(If checked, does the veteran have any residuals of the partial laryngectomy?)

☐ YES ☐ NO

(If "Yes," describe): _____

C3. DOES THE VETERAN HAVE LARYNGEAL STENOSIS, INCLUDING RESIDUALS OF LARYNGEAL TRAUMA *(unilateral or bilateral)?*

☐ YES ☐ NO *(If "Yes," assess for upper airway obstruction with pulmonary function testing to include Flow-Volume Loop, and provide results in Section V, Diagnostic Testing)*

C4. DOES THE VETERAN HAVE COMPLETE ORGANIC APHONIA?

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

☐ Constant inability to speak above a whisper

☐ Constant inability to communicate by speech

☐ Other *(describe):* _____

C5. DOES THE VETERAN HAVE INCOMPLETE ORGANIC APHONIA?

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

☐ Hoarseness *(If checked, describe frequency):* _____

☐ Inflammation of vocal cords or mucous membrane

☐ Thickening or nodules of vocal chords

☐ Submucous infiltration of vocal chords

☐ Vocal chord polyps

☐ Other *(describe):* _____

C6. HAS THE VETERAN HAD A PERMANENT TRACHEOSTOMY?

☐ YES ☐ NO *(If "Yes," describe reason for tracheostomy and potential for decannulation):*

C7. HAS THE VETERAN HAD AN INJURY TO THE PHARYNX?

☐ YES ☐ NO *(If "Yes," check all findings, signs and symptoms that apply):*

☐ Stricture or obstruction of the pharynx or nasopharynx

☐ Absence of the soft palate secondary to trauma

☐ Absence of the soft palate secondary to chemical burn

☐ Absence of the soft palate secondary to granulomatous disease

☐ Paralysis of the soft palate with swallowing difficulty (nasal regurgitation) and speech impairment

☐ Other *(describe):* _____

C8. DOES THE VETERAN HAVE VOCAL CHORD PARALYSIS OR ANY OTHER PHARYNGEAL OR LARYNGEAL CONDITIONS?

☐ YES ☐ NO *(If "Yes," describe):*

PART D - DEVIATED NASAL SEPTUM *(TRAUMATIC)*

D1. IS THERE AT LEAST 50% OBSTRUCTION OF THE NASAL PASSAGE ON BOTH SIDES DUE TO TRAUMATIC SEPTAL DEVIATION?

☐ YES ☐ NO

D2. IS THERE COMPLETE OBSTRUCTION ON ONE SIDE DUE TO TRAUMATIC SEPTAL DEVIATION?

☐ YES ☐ NO

PART E - TUMORS AND NEOPLASMS

E1. 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 7B through 7E)*

E2. IS THE NEOPLASM:

☐ BENIGN ☐ MALIGNANT

E3. 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): _____

E4. 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 ABOVE?

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

E5. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS, DESCRIBE USING THE ABOVE FORMAT:

PART F - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

F1. DOES THE VETERAN HAVE ANY SCARS *(surgical or otherwise)* related 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.

F2. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

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

SECTION V - DIAGNOSTIC TESTING

NOTE - If testing has been performed and reflects the veteran's current condition, repeat testing is not required. Specific diagnostic testing is not required for many conditions, but if performed, record in this section.

5A. HAVE IMAGING STUDIES OF THE SINUSES OR OTHER AREAS BEEN PERFORMED?

☐ YES ☐ NO

(If "Yes," check all that apply)

☐ Magnetic resonance imaging *(MRI)* Date: _____ Results: _____

☐ Computed tomography *(CT)* Date: _____ Results: _____

☐ X-rays: _____ Date: _____ Results: _____

☐ Other: _____ Date: _____ Results: _____

5B. HAS ENDOSCOPY BEEN PERFORMED?

☐ YES ☐ NO

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

☐ Nasal endoscopy Date: _____ Results: _____

☐ Laryngeal endoscopy Date: _____ Results: _____

☐ Bronchoscopy Date: _____ Results: _____

☐ Other endoscopy Date: _____ Results: _____

5C. HAS THE VETERAN HAD A BIOPSY OF THE LARYNX OR PHARYNX?

☐ YES ☐ NO

(If "Yes," complete the following):

Site of biopsy: _____ Date: _____

Results: ☐ Benign ☐ Pre-malignant ☐ Malignant

Describe results: _____

5D. HAS THE VETERAN HAD PULMONARY FUNCTION TESTING TO ASSESS FOR UPPER AIRWAY OBSTRUCTION DUE TO LARYNGEAL STENOSIS?

☐ YES ☐ NO

(If "Yes," indicate results)

☐ FEV-1 of 71 to 80% predicted

☐ FEV-1 of 56 to 70% predicted

☐ FEV-1 of 40 to 55% predicted

☐ FEV-1 less than 40% predicted

(Is the Flow-Volume Loop compatible with upper airway obstruction?)

☐ YES ☐ NO

5E. 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 VI - FUNCTIONAL IMPACT

6. DOES THE VETERAN'S SINUS, NOSE, THROAT, LARYNX OR PHARYNX CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact of each of the veteran's sinus, nose, throat, larynx or pharynx conditions, providing one or more examples):*

SECTION VII - REMARKS

7. REMARKS *(If any)*

SECTION VIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

8A. PHYSICIAN'S SIGNATURE	8B. PHYSICIAN'S PRINTED NAME	8C. DATE SIGNED

8D. PHYSICIAN'S PHONE AND FAX NUMBERS	8E. PHYSICIAN'S MEDICAL LICENSE NUMBER	8F. 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.