



NON-DEGENERATIVE ARTHRITIS (INCLUDING INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE AND INFECTIOUS ARTHRITIS) AND DYSBARIC OSTEONECROSIS 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 ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

NOTE TO PHYSICIAN - The veteran or service member 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 claim. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

MEDICAL RECORD REVIEW

WAS THE VETERAN'S VA CLAIMS FILE REVIEWED?

YES NO

IF YES, LIST ANY RECORDS THAT WERE REVIEWED BUT WERE NOT INCLUDED IN THE VETERAN'S VA CLAIMS FILE:

IF NO, CHECK ALL RECORDS REVIEWED:

- | | |
|---|---|
| <input type="checkbox"/> Military service treatment records | <input type="checkbox"/> Department of Defense Form 214 Separation Documents |
| <input type="checkbox"/> Military service personnel records | <input type="checkbox"/> Veterans Health Administration medical records (<i>VA treatment records</i>) |
| <input type="checkbox"/> Military enlistment examination | <input type="checkbox"/> Civilian medical records |
| <input type="checkbox"/> Military separation examination | <input type="checkbox"/> Interviews with collateral witnesses (<i>family and others who have known the veteran before and after military service</i>) |
| <input type="checkbox"/> Military post-deployment questionnaire | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> No records were reviewed | |

NOTE: Complete this Questionnaire if the Veteran has an inflammatory, autoimmune, crystalline or infectious arthritis, or dysbaric osteonecrosis (Caisson disease of bone). If the Veteran has degenerative arthritis (osteoarthritis) or traumatic arthritis, do not complete this Questionnaire, INSTEAD complete the joint Questionnaire for the affected area (e.g., if the diagnosis is osteoarthritis of the knee, complete the Knee Questionnaire). If the Veteran has arthritis due to systemic lupus erythematosus (SLE), instead complete the SLE Questionnaire.

SECTION I - DIAGNOSIS

NOTE: These are condition(s) for which an evaluation has been requested on an exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. LIST THE CLAIMED CONDITION(S) THAT PERTAIN TO THIS DBQ:

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 comments section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date determined through record review or reported history.

1B. SELECT DIAGNOSES ASSOCIATED WITH THE CLAIMED CONDITION(S) (*Check all that apply*):

- The Veteran does not have a current diagnosis associated with any claimed condition listed above. (*Explain your findings and reasons in comments section.*)
- | | | |
|---|-----------------|--------------------------|
| <input type="checkbox"/> Gout | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Rheumatoid arthritis (<i>atrophic</i>) | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Gonorrheal arthritis | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Pneumococccic arthritis | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Typhoid arthritis | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Syphilitic arthritis | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Streptococccic arthritis | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Dysbaric osteonecrosis
(<i>Caisson Disease of Bone</i>) | ICD Code: _____ | Date of diagnosis: _____ |
- Other (*specify*) (*If checked, provide only diagnoses that pertain to inflammatory, autoimmune, crystalline or infectious arthritis.*)
- Other diagnosis #1: _____ ICD Code: _____ Date of diagnosis: _____
- Other diagnosis #2: _____ ICD Code: _____ Date of diagnosis: _____
- Other diagnosis #3: _____ ICD Code: _____ Date of diagnosis: _____

SECTION III - JOINT INVOLVEMENT (Continued)

3C. DOES THE VETERAN HAVE ANY JOINT DEFORMITIES ATTRIBUTABLE TO THE ARTHRITIS CONDITION?

YES NO

IF YES, INDICATE AFFECTED JOINTS (*check all that apply*):

CERVICAL SPINE THORACOLUMBAR SPINE SACROILIAC JOINTS

RIGHT: SHOULDER ELBOW WRIST HAND/FINGERS HIP KNEE ANKLE FOOT/TOES

LEFT: SHOULDER ELBOW WRIST HAND/FINGERS HIP KNEE ANKLE FOOT/TOES

FOR ALL CHECKED JOINTS, DESCRIBE DEFORMITIES (*brief summary*):

3D. COMMENTS (*if any*):

NOTE: For pain, limitation of joint movement and joint deformities, ALSO complete the appropriate DBQ for each affected joint, if indicated. ALSO complete the appropriate DBQ for each affected system, if indicated.

SECTION IV - SYSTEMIC INVOLVEMENT OTHER THAN JOINTS

4A. DOES THE VETERAN HAVE ANY INVOLVEMENT OF ANY SYSTEMS, OTHER THAN JOINTS, ATTRIBUTABLE TO THIS ARTHRITIS CONDITION?

YES NO

IF YES, INDICATE SYSTEMS INVOLVED (*check all that apply*):

OPHTHALMOLOGICAL SKIN AND MUCOUS MEMBRANES HEMATOLOGIC PULMONARY CARDIAC

NEUROLOGIC RENAL GASTROINTESTINAL VASCULAR

FOR ALL CHECKED SYSTEMS, DESCRIBE INVOLVEMENT (*brief summary*) (*Also complete the appropriate DBQ for each affected system, if indicated*):

4B. COMMENTS (*if any*):

SECTION V - INCAPACITATING AND NON-INCAPACITATING EXACERBATIONS

5A. DUE TO THE ARTHRITIS CONDITION, DOES THE VETERAN HAVE EXACERBATIONS WHICH ARE NOT INCAPACITATING?

YES NO

IF YES, INDICATE FREQUENCY OF NON-INCAPACITATING EXACERBATIONS PER YEAR:

0 1 2 3 4 OR MORE

Date of most recent non-incapacitating exacerbation: _____

Duration of most recent non-incapacitating exacerbation: _____

Describe non-incapacitating exacerbation: _____

5B. DUE TO THE ARTHRITIS CONDITION, DOES THE VETERAN HAVE EXACERBATIONS WHICH ARE INCAPACITATING?

YES NO

IF YES, INDICATE FREQUENCY OF INCAPACITATING EXACERBATIONS PER YEAR (*on average*):

0 1 2 3 4 OR MORE

INDICATE THE TOTAL DURATION OF INCAPACITATION OVER THE PAST 12 MONTHS:

< 1 WEEK

1 WEEK TO < 2 WEEKS

2 WEEKS TO < 4 WEEKS

4 WEEKS TO < 6 WEEKS

6 WEEKS OR MORE

Date of most recent incapacitating exacerbation: _____

Duration of most recent incapacitating exacerbation: _____

Describe incapacitating exacerbation: _____

5C. IS THE VETERAN'S ARTHRITIS MANIFESTED BY CONSTITUTIONAL MANIFESTATIONS ASSOCIATED WITH ACTIVE JOINT INVOLVEMENT WHICH ARE TOTALLY INCAPACITATING?

YES NO

SECTION V - INCAPACITATING AND NON-INCAPACITATING EXACERBATIONS (Continued)

5D. IS THE VETERAN'S ARTHRITIS MANIFESTED BY WEIGHT LOSS AND ANEMIA PRODUCTIVE OF SEVERE IMPAIRMENT OF HEALTH?

YES NO

5E. IS THE VETERAN'S ARTHRITIS MANIFESTED BY SEVERELY INCAPACITATING EXACERBATIONS OCCURRING 4 OR MORE TIMES A YEAR OR A LESSER NUMBER OVER PROLONGED PERIODS?

YES NO

5F. IS THE VETERAN'S ARTHRITIS MANIFESTED BY SYMPTOM COMBINATIONS PRODUCTIVE OF DEFINITE IMPAIRMENT OF HEALTH OBJECTIVELY SUPPORTED BY EXAMINATION FINDINGS?

YES NO

5G. COMMENTS (if any):

SECTION VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS AND SCARS

6A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS, OR ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES NO IF YES, COMPLETE QUESTIONS 6B-6D.

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

YES NO IF YES, DESCRIBE (brief summary):

6C. 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 ABOVE?

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.

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 Comment section below. It is not necessary to also complete a Scars DBQ.

6D. COMMENTS, IF ANY:

SECTION VII - ASSISTIVE DEVICES

7A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

YES NO IF YES, IDENTIFY ASSISTIVE DEVICES USED (check all that apply and indicate frequency):

<input type="checkbox"/> Wheelchair	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Brace	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Crutches	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Cane	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Walker	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant
<input type="checkbox"/> Other: _____	Frequency of use:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Regular	<input type="checkbox"/> Constant

7B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

