



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 I - DIAGNOSIS (Continued)

1C. COMMENTS (if any):

1D. WAS AN OPINION REQUESTED ABOUT THIS CONDITION (internal VA only)?

YES NO N/A IF YES, INCLUDE MEDICAL OPINION DBQ.

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE OR INFECTIOUS ARTHRITIS OR DYSBARIC OSTEONECROSIS (brief summary):

2B. DOES THE VETERAN REQUIRE CONTINUOUS USE OF MEDICATION FOR THE ARTHRITIS CONDITION?

YES NO

IF YES, LIST ONLY THOSE MEDICATIONS USED FOR THIS ARTHRITIS:

2C. HAS THE VETERAN LOST WEIGHT DUE TO THE ARTHRITIS CONDITION?

YES NO

IF YES, PROVIDE BASELINE WEIGHT (average weight for 2-year period preceding onset of disease): _____, AND CURRENT WEIGHT _____

IF YES, DOES THE VETERAN'S WEIGHT LOSS ATTRIBUTABLE TO THE ARTHRITIS CONDITION CAUSE IMPAIRMENT OF HEALTH?

YES NO

IF YES, DESCRIBE THE IMPAIRMENT:

2D. DOES THE VETERAN HAVE ANEMIA DUE TO THE ARTHRITIS CONDITION?

YES NO

IF YES, DOES THE VETERAN'S ANEMIA ATTRIBUTABLE TO THE ARTHRITIS CONDITION CAUSE IMPAIRMENT OF HEALTH?

YES NO

IF YES, DESCRIBE THE IMPAIRMENT (also provide CBC under diagnostic testing section #9):

SECTION III - JOINT INVOLVEMENT

3A. DOES THE VETERAN HAVE PAIN (with or without joint movement) ATTRIBUTABLE TO THIS 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 INVOLVEMENT (brief summary):

3B. DOES THE VETERAN HAVE ANY LIMITATION OF JOINT MOVEMENT 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 LIMITATION OF MOVEMENT (brief summary):

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:

SECTION VIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

8. DUE TO THE VETERAN'S ARTHRITIS CONDITION, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTIONS REMAINS OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? (*Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.*)

- YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROTHESIS WOULD EQUALLY SERVE THE VETERAN.
 NO

IF YES, INDICATE EXTREMITIES FOR WHICH THIS APPLIES: RIGHT UPPER LEFT UPPER RIGHT LOWER LEFT LOWER

FOR EACH CHECKED EXTREMITY, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, DESCRIBE LOSS OF EFFECTIVE FUNCTION AND PROVIDE SPECIFIC EXAMPLES (*brief summary*):

NOTE: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prosthesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

SECTION IX - DIAGNOSTIC TESTING

NOTE: Testing listed below is not indicated for every condition.

9A. HAVE IMAGING STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

- YES NO

IF YES, INDICATE TYPE OF STUDY:

- X-RAY Area(s) imaged: _____ Date: _____ Results: _____
 OTHER, SPECIFY: _____
 Area(s) imaged: _____ Date: _____ Results: _____

9B. HAVE LABORATORY STUDIES BEEN PERFORMED?

- YES NO

IF YES, CHECK ALL THAT APPLY:

IF ANY TEST RESULTS IN THIS SECTION (*Section B*) ARE OTHER THAN NORMAL, INCLUDE NORMAL REFERENCE RANGES FOR YOUR FACILITY.

- ERYTHROCYTE SEDIMENTATION RATE (*ESR*) Date of test: _____ Results: _____
 C-REACTIVE PROTEIN Date of test: _____ Results: _____
 RHEUMATOID FACTOR (*RF*) Date of test: _____ Results: _____
 ANTI-DNA ANTIBODIES Date of test: _____ Results: _____
 ANTINUCLEAR ANTIBODIES (*ANA*) Date of test: _____ Results: _____
 ANTI-CYCLIC CITRULLINATED PEPTIDE (ANTI-CCP) ANTIBODIES Date of test: _____ Results: _____
 CBC Date of test: _____
 Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____
 URIC ACID TEST Date of test: _____ Results: _____
 OTHER, SPECIFY: _____ Date of test: _____ Results: _____

9C. HAS THE VETERAN HAD A JOINT ASPIRATION OR SYNOVIAL FLUID ANALYSIS?

- YES NO

IF YES, INDICATE JOINT ASPIRATED, DATE AND RESULTS:

9D. HAS THE VETERAN HAD A BIOPSY (*e.g., skin, nerve, fat, rectum, kidney*)?

- YES NO

IF YES, INDICATE AREA BIOPSIED, DATE AND RESULTS:

9E. 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*):

9F. IF ANY TEST RESULTS ARE OTHER THAN NORMAL, INDICATE RELATIONSHIP OF ABNORMAL FINDINGS TO DIAGNOSED CONDITIONS:

SECTION X - FUNCTIONAL IMPACT

NOTE: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

10. REGARDLESS OF THE VETERAN'S CURRENT EMPLOYMENT STATUS, DO THE CONDITION(S) LISTED IN THE DIAGNOSIS SECTION IMPACT HIS OR HER ABILITY TO PERFORM ANY TYPE OF OCCUPATIONAL TASK (*such as standing, walking, lifting, sitting, etc.*)?

YES NO IF YES, DESCRIBE THE FUNCTIONAL IMPACT OF EACH CONDITION, PROVIDING ONE OR MORE EXAMPLES:

SECTION XI - REMARKS

11. 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.

12A. PHYSICIAN'S SIGNATURE		12B. PHYSICIAN'S PRINTED NAME	12C. DATE SIGNED
12D. PHYSICIAN'S PHONE AND FAX NUMBER	12E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	12F. 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.vba.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 required to obtain or retain benefits. 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.