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

Department of Veterans Affairs

SEIZURE DISORDERS (EPILEPSY) 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 *(First, Middle Initial, Last)*

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 BEEN DIAGNOSED WITH A SEIZURE DISORDER *(epilepsy)? (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 APPROPRIATE DIAGNOSIS: *(check all that apply):*

☐ TONIC-CLONIC SEIZURES OR GRAND MAL EPILEPSY *(generalized convulsive seizures)*	ICD Code: _____	Date of diagnosis: _____
☐ ABSENCE SEIZURES OR PETIT MAL OR ATONIC SEIZURES *(generalized non-convulsive seizures)*	ICD Code: _____	Date of diagnosis: _____
☐ JACKSONIAN *(simple partial seizures)*	ICD Code: _____	Date of diagnosis: _____
☐ FOCAL MOTOR	ICD Code: _____	Date of diagnosis: _____
☐ FOCAL SENSORY	ICD Code: _____	Date of diagnosis: _____
☐ DIENCEPHALIC EPILEPSY	ICD Code: _____	Date of diagnosis: _____
☐ PSYCHOMOTOR EPILEPSY *(complex partial seizures, temporal lobe seizures)*	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 SEIZURE DISORDERS *(epilepsy)*, 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 SEIZURE DISORDER *(epilepsy) (brief summary)*:

3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF EPILEPSY OR SEIZURE ACTIVITY?

☐ YES ☐ NO *(If "Yes," list only those medications required for the veteran's epilepsy or seizure activity)*

3C. HAS THE VETERAN HAD ANY OTHER TREATMENT *(such as surgery)* FOR EPILEPSY OR SEIZURE ACTIVITY?

☐ YES ☐ NO *(If "Yes," describe):*

3D. HAS THE DIAGNOSIS OF A SEIZURE DISORDER BEEN CONFIRMED?

☐ YES ☐ NO *(If "Yes," describe):*

3E. HAS THE VETERAN HAD A WITNESSED SEIZURE?

☐ YES ☐ NO *(If "Yes," describe, including relationship of witnesses to veteran):*

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SECTION IV - FINDINGS, SIGNS AND SYMPTOMS

4. DOES THE VETERAN HAVE OR HAS HE OR SHE HAD ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO SEIZURE DISORDER *(epilepsy)* ACTIVITY?

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

- ☐ Generalized tonic-clonic convulsion
- ☐ Episodes of unconsciousness
- ☐ Brief interruption in consciousness or conscious control
- ☐ Episodes of staring
- ☐ Episodes of rhythmic blinking of the eyes
- ☐ Episodes of nodding of the head
- ☐ Episodes of sudden jerking movement of the arms, trunk or head (myoclonic type)
- ☐ Episodes of sudden loss of postural control (akinetic type)
- ☐ Episodes of complete or partial loss of use of one or more extremities
- ☐ Episodes of random motor movements
- ☐ Episodes of psychotic manifestations
- ☐ Episodes of hallucinations
- ☐ Episodes of perceptual illusions
- ☐ Episodes of abnormalities of thinking
- ☐ Episodes of abnormalities of memory
- ☐ Episodes of abnormalities of mood
- ☐ Episodes of autonomic disturbances
- ☐ Episodes of speech disturbances
- ☐ Episodes of impairment of vision
- ☐ Episodes of disturbances of gait
- ☐ Episodes of tremors
- ☐ Episodes of visceral manifestations
- ☐ Residuals of Injury during seizure
- ☐ Other

(For all checked conditions describe):

SECTION V - TYPE AND FREQUENCY OF SEIZURE ACTIVITY

5.A. DOES THE VETERAN HAVE OR HAS HE OR SHE EVER HAD ANY TYPE OF SEIZURE ACTIVITY, INCLUDING MAJOR, MINOR, PETIT MAL OR PSYCHOMOTOR SEIZURE ACTIVITY?

☐ YES ☐ NO *(If "Yes," complete Items 5B through 5H)*

5B. PROVIDE APPROXIMATE DATE OF FIRST SEIZURE ACTIVITY *(Month, Year)* _____

PROVIDE DATE OF MOST RECENT SEIZURE ACTIVITY *(Month, Year)* _____

5C. HAS THE VETERAN EVER HAD MINOR SEIZURES *(characterized by a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head ("pure" petit mal) or sudden jerking movements of the arms, trunk or head (myoclonic type) or sudden loss of postural control (akinetic type))?*

☐ YES ☐ NO *(If "Yes," complete the following):*

Number of minor seizures over past 6 months:

- ☐ 0-1
- ☐ 2 or more

If 2 or more over the past 6 months, indicate the average frequency of minor seizures:

☐ 0-4 per week ☐ 5-8 per week ☐ 9-10 per week ☐ More than 10 per week

5D. HAS THE VETERAN EVER HAD MAJOR SEIZURES *(characterized by the generalized tonic-clonic convulsion with unconsciousness)?*

☐ YES ☐ NO *(If "Yes," complete the following):*

Number of major seizures:

☐ None in past 2 years ☐ At least 1 in past 2 years ☐ At least 2 in past year

Average frequency of major seizures:

- ☐ Less than 1 in past 6 months
- ☐ At least 1 in past 6 months
- ☐ At least 1 in 4 months over past year
- ☐ At least 1 in 3 months over past year
- ☐ At least 1 per month over past year

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SECTION IV - TYPE AND FREQUENCY OF SEIZURE ACTIVITY *(Continued)*

5E. HAS THE VETERAN EVER HAD MINOR PSYCHOMOTOR SEIZURES *(characterized by brief transient episodes of random motor movements, hallucinations, perceptual illusions, abnormalities of thinking, memory or mood, or autonomic disturbances)?*

☐ YES ☐ NO *(If "Yes," complete the following):*

Number of minor seizures over past 6 months:

☐ 0-1

☐ 2 or more

If 2 or more over the past 6 months, indicate the average frequency of minor seizures:

☐ 0-4 per week ☐ 5-8 per week ☐ 9-10 per week ☐ More than 10 per week

5F. HAS THE VETERAN EVER HAD MAJOR PSYCHOMOTOR SEIZURES *(major psychomotor seizures are characterized by automatic states and/or generalized convulsions with unconsciousness)?*

☐ YES ☐ NO *(If "Yes," complete the following):*

Number of major psychomotor seizures:

☐ None in past 2 years

☐ At least 1 in past 2 years

☐ At least 2 in past year

Average frequency of major psychomotor seizures:

☐ Less than 1 in past 6 months

☐ At least 1 in past 6 months

☐ At least 1 in 4 months over past year

☐ At least 1 in 3 months over past year

☐ At least 1 per month over past year

5G. HAS THE VETERAN EVER HAD EPILEPSY ASSOCIATED WITH A NONPSYCHOTIC ORGANIC BRAIN SYNDROME?

☐ YES ☐ NO *(If "Yes," describe):*

5H. HAS THE VETERAN EVER HAD EPILEPSY ASSOCIATED WITH A PSYCHOTIC DISORDER, PSYCHONEUROTIC DISORDER OR PERSONALITY DISORDER?

☐ YES ☐ NO *(If "Yes," the appropriate Mental Disorder Questionnaire must ALSO be completed)*

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

6A. 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.

6B. 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 VII - DIAGNOSTIC TESTING

NOTE - If diagnostic test results are in the medical record and reflect the veteran's current seizure (epilepsy) disorder, repeat testing is not required.

7A. HAVE ANY IMAGING STUDIES OR DIAGNOSTIC PROCEDURES BEEN PERFORMED?

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

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

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

☐ Cerebrospinal fluid CSF examination Date: _____ Results: _____

☐ Electroencephalography *(EEG)* Date: _____ Results: _____

☐ Neuropsychologic testing Date: _____ Results: _____

☐ Other *(describe):* _____ Date: _____ Results: _____

7B. 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)):*

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SECTION VIII - FUNCTIONAL IMPACT

8. DOES THE VETERAN'S EPILEPSY OR SEIZURE *(epilepsy)* DISORDER IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of the veteran's seizure (epilepsy) disorder, providing one or more examples):*

SECTION IX - REMARKS

9. REMARKS *(If any)*

SECTION X - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

10A. PHYSICIAN'S SIGNATURE	10B. PHYSICIAN'S PRINTED NAME	10C. DATE SIGNED

10D. PHYSICIAN'S PHONE/FAX NUMBERS	10E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	10F. 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.