Department of Veterans Affairs

DIABETES MELLITUS
DISABILITY BENEFITS QUESTIONNAIRE

Name of Patient/Veteran	Patient/Veteran's Social Security Number	Date of examination:

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.

Note - The Veteran 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 may obtain additional medical information, including an examination, if necessary, to complete VA's review of the Veteran's application. VA reserves the right to confirm the authenticity of ALL completed questionnaires. **It is intended that this questionnaire will be completed by the Veteran's healthcare provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

☐ Veteran/Claimant

☐ Third party (please list name(s) of organization(s) or individual(s))

☐ Other: please describe

Are you a VA Healthcare provider? ◯ Yes ◯ No

Is the Veteran regularly seen as a patient in your clinic? ◯ Yes ◯ No

Was the Veteran examined in person? ◯ Yes ◯ No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

◯ No records were reviewed

◯ Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

SECTION I - DIAGNOSIS

1A. Select the Veteran's condition:

Is there an official diagnosis of Diabetes Mellitus Type I?

◯ Yes ◯ No ICD Code: Date of Diagnosis:

Is there an official diagnosis of Diabetes Mellitus Type II?

◯ Yes ◯ No ICD Code: Date of Diagnosis:

☐ Impaired fasting glucose

☐ Does not meet criteria for diagnosis of diabetes

☐ Other (Specify below, providing only diagnoses that pertain to Diabetes Mellitus or its complications)

Diagnosis # 1:		ICD Code:		Date of diagnosis:	
Diagnosis # 2:		ICD Code:		Date of diagnosis:	
Diagnosis # 3:		ICD Code:		Date of diagnosis:	

1B. If there are additional diagnoses that pertain to Diabetes Mellitus list using above format

SECTION II - MEDICAL HISTORY

2A. Treatment (Check all that apply)

- ☐ None
- ☐ Managed by restricted diet
- ☐ Prescribed oral hypoglycemic agent(s)
- ☐ Insulin required
  - ◯ 1 injection per day
  - ◯ More than 1 injection per day
- ☐ Other (Describe)

2B. Regulation of activities

Does the Veteran require regulation of activities as part of medical management of Diabetes Mellitus?

◯ Yes ◯ No (If "Yes," provide one or more examples of how the Veteran must regulate his or her activities):

NOTE - For VA purposes, regulation of activities can be defined as avoidance of strenuous occupational and recreational activities with the intention of avoiding hypoglycemic episodes.

2C. Frequency of diabetic care

How frequently does the Veteran visit his or her diabetic care provider for episodes of ketoacidosis?

◯ Less than 2 times per month ◯ 2 times per month ◯ Weekly

How frequently does the Veteran visit his or her diabetic care provider for episodes of hypoglycemia?

◯ Less than 2 times per month ◯ 2 times per month ◯ Weekly

2D. Hospitalization for episodes of ketoacidosis or hypoglycemic reactions

How many episodes of ketoacidosis required hospitalization over the past 12 months?

◯ 0 ◯ 1 ◯ 2 ◯ 3 or more

How many episodes of hypoglycemic reactions required hospitalization over the past 12 months?

◯ 0 ◯ 1 ◯ 2 ◯ 3 or more

2E. Loss of strength and weight

Has the Veteran had progressive unintentional weight loss and loss of strength attributable to Diabetes Mellitus?

◯ Yes ◯ No (If "Yes," provide percent of loss of individual's baseline weight): _____ %

NOTE - For VA purposes, "baseline weight" means the average weight for the two-year period preceding the onset of the disease.

SECTION III - COMPLICATIONS OF DIABETES MELLITUS

3A. Does the Veteran have any of the following recognized complications of diabetes mellitus?

◯ Yes ◯ No

(If "Yes," indicate the conditions below) (Check all that apply)

☐ Diabetic peripheral neuropathy

☐ Diabetic nephropathy or renal dysfunction caused by Diabetes Mellitus

☐ Diabetic retinopathy

NOTE - For all checked boxes, also complete appropriate Questionnaire(s). (Eye Questionnaire must be completed by an ophthalmologist or optometrist)

3B. Does the Veteran have any of the following conditions that are at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) due to Diabetes Mellitus?

◯ Yes ◯ No

(If "Yes," indicate the conditions below) (Check all that apply)

☐ Erectile dysfunction

☐ Female Sexual Arousal Disorder (FSAD) (If checked, also complete the Gynecological Conditions Questionnaire)

☐ Cardiac condition(s) (If checked also complete the Heart Conditions Questionnaire)

☐ Hypertension (in the presence of diabetic renal disease) (If checked also complete Hypertension Questionnaire)

☐ Peripheral vascular disease (If checked also complete Arteries and Veins Questionnaire)

☐ Stroke (If checked also complete appropriate neurological Questionnaire(s) Central Nervous System, Cranial Nerves, etc.)

☐ Skin Conditions (If checked also complete Skin Conditions Questionnaire)

☐ Eye conditions other than diabetic retinopathy (If checked also complete Eye Questionnaire. Eye Questionnaire must be completed by an ophthalmologist or optometrist)

☐ Other complication(s) (Describe)

3C. Has the Veteran's Diabetes Mellitus at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) permanently aggravated (meaning that any worsening of the condition is not due to natural progress) any of the following conditions?

◯ Yes ◯ No

(If "Yes," indicate the conditions below) (Check all that apply)

☐ Erectile Dysfunction

☐ Female Sexual Arousal Disorder (FSAD) (If checked, also complete the Gynecological Conditions Questionnaire)

☐ Cardiac condition(s) (If checked also complete the Heart Conditions Questionnaire)

☐ Hypertension (If checked also complete Hypertension Questionnaire)

☐ Renal Disease other than diabetic nephropathy or renal disfunction caused by diabetes mellitus (If checked, also complete Kidney Questionnaire)

☐ Peripheral vascular disease (If checked also complete Artery and Vein Questionnaire)

☐ Eye condition(s) other than diabetic retinopathy.(If checked also complete Eye Questionnaire. Eye Questionnaire must be completed by an ophthalmologist or optometrist.

☐ Skin Conditions (If checked, also complete Skin Conditions Questionnaire)

☐ Other permanently aggravated condition(s) (Describe)

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

4A. 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).

4B. 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, is there objective evidence that 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? 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

◯ 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.

4C. Comments, if any:

SECTION V - DIAGNOSTIC TESTING

5A. Test results used to make the diagnosis of Diabetes Mellitus (if known) (check all that apply)

Note: If laboratory test results are in the medical record, repeat testing is not required. A glucose tolerance test is not required for VA purposes; report this test only if already completed.

- ☐ Fasting plasma glucose test (FPG) of ≥ 126 mg/dl on 2 or more occasions — Dates _____
- ☐ A1C of 6.5% or greater on 2 or more occasions — Dates _____
- ☐ 2-hr plasma glucose of ≥ 200 mg/dl on glucose tolerance test — Dates _____
- ☐ Random plasma glucose of ≥ 200 mg/dl with classic symptoms of hyperglycemia — Dates _____
- ☐ Other, describe

5B. Current test results

Most recent A1C, if available: _____ Date _____

Most recent fasting plasma glucose, if available: _____ Date _____

SECTION VI - 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.

6A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/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 VII - REMARKS

7A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

SECTION VIII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

8A. Examiner's signature:	8B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

8C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	8D. Date Signed:

8E. Examiner's phone/fax numbers:	8F. National Provider Identifier (NPI) number:	8G. Medical license number and state:

8H. Examiner's address: