Department of Veterans Affairs

NUTRITIONAL DEFICIENCIES 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. DOES THE VETERAN CURRENTLY HAVE A DIAGNOSED NUTRITIONAL DEFICIENCY?

◯ Yes ◯ No

1B. IF YES, SELECT THE VETERAN'S CONDITION (check all that apply)

☐ AVITAMINOSIS	ICD Code:		Date of diagnosis:	
☐ BERIBERI (Vitamin B1 or thiamine deficiency)	ICD Code:		Date of diagnosis:	
☐ PELLAGRA (Vitamin B3 or niacin deficiency)	ICD Code:		Date of diagnosis:	

☐ OTHER NUTRITIONAL DEFICIENCY CONDITION (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 NUTRITIONAL DEFICIENCIES, LIST USING ABOVE FORMAT:

NOTE - For all identified complications or residual conditions, ALSO complete additional questionnaires as appropriate (such as skin, heart, peripheral nerves, etc.)

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S NUTRITIONAL DEFICIENCY CONDITION(S) (brief summary):

2B. DOES THE VETERAN'S NUTRITIONAL DEFICIENCY CONDITION REQUIRE CONTINUOUS MEDICATIONS FOR CONTROL?

◯ Yes ◯ No

If yes, list only those medications used for the diagnosed condition(s):

SECTION III - FINDINGS, SIGNS AND SYMPTOMS

3A. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO PELLAGRA OR AVITAMINOSIS?

◯ Yes ◯ No If "Yes," check all that apply:

☐ Confirmed diagnosis

☐ Nonspecific symptoms such as decreased appetite, weight loss, abdominal discomfort, weakness, inability to concentrate and irritability

☐ Stomatitis

- [ ] Achlorhydria
- [ ] Diarrhea
- [ ] Symmetrical dermatitis
- [ ] Mental symptoms
- [ ] Impaired bodily vigor
- [ ] Marked mental changes, moist dermatitis, inability to retain nourishment, exhaustion and cachexia
- [ ] Other

FOR ALL CHECKED CONDITIONS, DESCRIBE:

3B. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO ACTIVE BERIBERI?

◯ Yes ◯ No If "Yes," check all that apply:

- [ ] Peripheral neuropathy with absent knee or ankle jerks and loss of sensation
- [ ] Symptoms such as weakness, fatigue, anorexia, dizziness, heaviness and stiffness of legs, headache, or sleep disturbance
- [ ] Cardiomegaly
- [ ] Peripheral neuropathy with foot drop or atrophy of thigh or calf muscles
- [ ] Congestive heart failure, anasarca, or Wernicke-Korsakoff syndrome
- [ ] Other

FOR ALL CHECKED CONDITIONS, DESCRIBE:

3C. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO RESIDUALS OF BERIBERI?

◯ Yes ◯ No

If "Yes," describe residual findings, signs and symptoms:

3D. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO CONDITIONS OR RESIDUALS CAUSED BY ANY OTHER VITAMIN DEFICIENCY?

◯ Yes ◯ No

If "Yes," describe:

NOTE: ALSO complete additional Questionnaires as appropriate (such as Mental Health, Skin, Peripheral Nerves, etc.) for all findings, signs, and symptoms identified above.

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

4A. 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):

4B. DOES THE VETERAN HAVE ANY SCARS OR OTHER DISFIGUREMENT (of the skin) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

◯ Yes ◯ No If "Yes," also complete appropriate dermatological DBQ

4C. COMMENTS, IF ANY:

SECTION V - DIAGNOSTIC TESTING

5A. ARE THERE ANY SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

◯ Yes ◯ No If "Yes," describe:

SECTION VI - FUNCTIONAL IMPACT

6A. DOES THE VETERAN'S NUTRITIONAL DEFICIENCY CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

◯ Yes ◯ No If "Yes," describe impact of each of the Veteran's nutritional deficiency condition(s), providing one or more examples:

SECTION VII - REMARKS

7A. REMARKS (If any)

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, 9DMD, 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: