Department of Veterans Affairs

LOSS OF SENSE OF SMELL AND/OR TASTE DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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 questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

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

☐ Veteran/Claimant

☐ 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 NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH LOSS OF SENSE OF SMELL OR TASTE? *(This is the condition the Veteran is claiming or for which an exam has been requested.)*

☐ YES ☐ NO

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

☐ ANOSMIA *(inability to detect any odor)*	ICD Code: _____	Date of diagnosis: _____
☐ HYPOSMIA *(reduced ability to detect any odors)*	ICD Code: _____	Date of diagnosis: _____
☐ AGEUSIA *(complete lack of taste)*	ICD Code: _____	Date of diagnosis: _____
☐ HYPOGEUSIA *(decrease in sense of taste)*	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 COMPLETE LOSS OF SENSE OF SMELL OR TASTE, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S LOSS OF SENSE OF SMELL OR TASTE *(brief summary):*

SECTION III - SYMPTOMS

3A. DOES THE VETERAN CURRENTLY HAVE LOSS OF SENSE OF SMELL?

☐ YES ☐ NO *(If "Yes," indicate severity)*

☐ PARTIAL
☐ COMPLETE

(If "Yes," is there a known anatomical or pathological basis for this condition?)

☐ YES ☐ NO *(If "Yes," describe)*

3B. DOES THE VETERAN CURRENTLY HAVE LOSS OF SENSE OF TASTE *(unable to detect sweet, salty, sour, or bitter tastes)?*

☐ YES ☐ NO *(If "Yes," indicate severity)*

☐ PARTIAL
☐ COMPLETE

(If "Yes," is there a known anatomical or pathological basis for this condition?)

☐ YES ☐ NO *(If "Yes," 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 THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

IF YES, DESCRIBE (*brief summary*):

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

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, 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? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

☐ 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: If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

4C. COMMENTS, IF ANY:

SECTION V - DIAGNOSTIC TESTING

NOTE: If testing has been performed and reflects the Veteran's current condition, repeat testing is not required. Specific diagnostic testing is not required for a loss of smell and taste examination.

5A. HAVE IMAGING OR LABORATORY STUDIES BEEN PERFORMED?

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

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

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

☐ Other: _____ Date: _____ Results: _____

5B. HAS QUALITATIVE SMELL TESTING BEEN PERFORMED?

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

Type of test: _____ Date: _____ Results: _____

5C. 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):*

SECTION VI - FUNCTIONAL IMPACT

6. DOES THE VETERAN'S LOSS OF SENSE OF SMELL OR TASTE IMPACT ON HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the Veteran's conditions related to the loss of sense of smell or taste, providing one or more examples):*

SECTION VII - REMARKS

7. REMARKS *(If any):*

SECTION VIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

8A. PHYSICIAN'S SIGNATURE	8B. PHYSICIAN'S PRINTED NAME	8C. DATE SIGNED

8D. PHYSICIAN'S PHONE AND FAX NUMBERS	8E. PHYSICIAN'S MEDICAL LICENSE NUMBER	8F. PHYSICIAN'S ADDRESS