Department of Veterans Affairs

STOMACH AND DUODENAL CONDITIONS (NOT INCLUDING GERD OR ESOPHAGEAL DISORDERS) 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 HAD ANY STOMACH OR DUODENUM CONDITIONS?

☐ YES ☐ NO *(If "Yes," complete Item 1B)*

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

☐	GASTRIC ULCER	ICD code:		Date of diagnosis:
☐	DUODENAL ULCER	ICD code:		Date of diagnosis:
☐	STENOSIS OF THE STOMACH	ICD code:		Date of diagnosis:
☐	MARGINAL (GASTROJEJUNAL) ULCER	ICD code:		Date of diagnosis:
☐	HYPERTROPHIC GASTRITIS	ICD code:		Date of diagnosis:
☐	POSTGASTRECTOMY SYNDROME	ICD code:		Date of diagnosis:
☐	STATUS POST VAGOTOMY WITH PYLOROPLASTY	ICD code:		Date of diagnosis:
☐	GASTROENTEROSTOMY	ICD code:		Date of diagnosis:
☐	PERITONEAL ADHESIONS FOLLOWING INJURY OR SURGERY OF THE STOMACH	ICD code:		Date of diagnosis:
☐	HELICOBACTER PYLORI	ICD code:		Date of diagnosis:

☐ OTHER STOMACH OR DUODENAL CONDITIONS

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 STOMACH OR DUODENUM CONDITIONS, LIST USING ABOVE FORMAT:

NOTE: The diagnosis of gastric or duodenal ulcer or stenosis can be made by upper gastrointestinal imaging series or endoscopy. The diagnosis of gastritis requires endoscopic confirmation. If testing is of record and is consistent with Veteran's current condition, repeat testing is not required.

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S STOMACH OR DUODENUM CONDITIONS *(brief summary):*

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITION?

☐ YES ☐ NO

IF YES, LIST ONLY THOSE MEDICATIONS USED FOR THE DIAGNOSED CONDITION:

SECTION III - SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR SYMPTOMS DUE TO ANY STOMACH OR DUODENUM CONDITIONS?

☐ YES ☐ NO

IF YES, *(check all that apply)*:

☐ Recurring episodes of symptoms that are not severe

If checked, indicate frequency of episodes of symptom recurrence per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of symptoms:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ Recurring episodes of severe symptoms

If checked, indicate frequency of episodes of symptom recurrence per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of symptoms:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ Abdominal Pain

If checked, indicate severity and frequency *(check all that apply)*:

☐ Occurs less than monthly
☐ Occurs at least monthly
☐ Pronounced
☐ Periodic
☐ Continuous
☐ Relieved by standard ulcer therapy
☐ Only partially relieved by standard ulcer therapy
☐ Unrelieved by standard ulcer therapy

☐ Anemia

If checked, provide hemoglobin/hematocrit in diagnostic testing section.

☐ Weight loss

If checked, provide baseline weight: _____ and current weight: _____

(For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease).

☐ Nausea

If checked, indicate severity:

☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic

If checked, indicate frequency of episodes of nausea per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of nausea:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ Vomiting

If checked, indicate severity:

☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic

If checked, indicate frequency of episodes of vomiting per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of vomiting:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ Hematemesis

If checked, indicate severity:

☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic

If checked, indicate frequency of episodes of hematemesis per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of hematemesis:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

☐ Melena

If checked, indicate severity:

☐ Mild ☐ Transient ☐ Recurrent ☐ Periodic

If checked, indicate frequency of episodes of melena per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

If checked, indicate average duration of episodes of melena:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

SECTION IV - INCAPACITATING EPISODES

4. DOES THE VETERAN HAVE INCAPACITATING EPISODES DUE TO SIGNS OR SYMPTOMS OF ANY STOMACH OR DUODENUM CONDITION?

☐ YES ☐ NO

IF YES, DESCRIBE INCAPACITATING EPISODES: _____

Indicate frequency of incapacitating episodes per year:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Indicate average duration of incapacitating episodes:

☐ Less than 1 day ☐ 1-9 days ☐ 10 days or more

SECTION V - OTHER CONDITIONS

5. DOES THE VETERAN HAVE ANY OF THE FOLLOWING CONDITIONS?

☐ YES ☐ NO

IF YES, INDICATE CONDITIONS AND COMPLETE APPROPRIATE SECTIONS *(check all that apply)*:

☐ Hypertrophic gastritis

If checked, indicate severity:

- ☐ No symptoms or findings
- ☐ Chronic, with small nodular lesions, and symptoms
- ☐ Chronic, with multiple small eroded or ulcerated areas, and symptoms
- ☐ Chronic, with severe hemorrhages, or large ulcerated or eroded areas

NOTE: If atrophic gastritis is present, state the underlying cause: _____

☐ Postgastrectomy syndrome

If checked, indicate severity:

- ☐ No symptoms or findings
- ☐ Mild; infrequent episodes of epigastric distress with characteristic mild circulatory symptoms or continuous mild manifestations
- ☐ Moderate; less frequent episodes of epigastric disorders with characteristic mild circulatory symptoms after meals but with diarrhea and weight loss
- ☐ Severe; associated with nausea, sweating, circulatory disturbance after meals, diarrhea, hypoglycemic symptoms, and weight loss with malnutrition and anemia

☐ Vagotomy with pyloroplasty or gastroenterostomy

If checked, indicate the severity of residuals following vagotomy with pyloroplasty or gastroenterostomy:

- ☐ No symptoms or findings
- ☐ Recurrent ulcer with incomplete vagotomy
- ☐ Symptoms and confirmed diagnosis of alkaline gastritis, or of confirmed persisting diarrhea
- ☐ Demonstrably confirmative postoperative complications of stricture or continuing gastric retention

☐ Peritoneal adhesions following an injury or surgical procedure of the stomach or duodenum

If checked, ALSO complete the Peritoneal Adhesions Questionnaire.

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 RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

IF YES, DESCRIBE (*brief summary*):

6B. 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.

6C. COMMENTS, IF ANY:

SECTION VII - DIAGNOSTIC TESTING

NOTE: If testing has been performed and reflects Veteran's current condition, no further testing is required for this examination report.
The diagnosis of gastric or duodenal ulcer or stenosis can be made by upper gastrointestinal imaging series or endoscopy.

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

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐ Upper endoscopy Date: _____ Results: _____

☐ Upper GI radiographic studies Date: _____ Results: _____

☐ MRI Date: _____ Results: _____

☐ CT Date: _____ Results: _____

☐ Biopsy, specify site: _____ Date: _____ Results: _____

☐ Other, specify: _____ Date: _____ Results: _____

7B. HAS LABORATORY TESTING BEEN PERFORMED?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

☐ CBC Date of test: _____

Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____

☐ Helicobacter pylori Date of test: _____ Results: _____

☐ Other, specify: _____ Date of test: _____ Results: _____

7C. 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 VIII - FUNCTIONAL IMPACT

8. DO ANY OF THE VETERAN'S STOMACH OR DUODENUM CONDITIONS IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

IF YES, DESCRIBE IMPACT OF EACH OF THE VETERAN'S STOMACH OR DUODENUM CONDITIONS, 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 AND FAX NUMBER	10E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	10F. PHYSICIAN'S ADDRESS