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	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

Note: These are condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. List the claimed condition(s) that pertain to this questionnaire:

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 approximate date determined through record review or reported history.

The diagnosis of peptic ulcer disease can be made by upper gastrointestinal diagnostic imaging studies or endoscopy. If testing is of record and is consistent with Veteran's current condition, repeat testing is not required. For stenosis of the stomach, complete the sections for peptic ulcer disease and complications of upper gastrointestinal surgery.

1B. Select diagnoses associated with the claimed condition(s) (check all that apply):

☐ The Veteran does not have a current diagnosis associated with any claimed condition(s) listed above. (Explain your findings and reasons in the remarks section)

☐	Peptic ulcer disease	ICD Code:		Date of diagnosis:
☐	Stenosis of the stomach	ICD Code:		Date of diagnosis:
☐	Stomach, injury of, residuals	ICD Code:		Date of diagnosis:
☐	Chronic gastritis (check all that apply, if known)	ICD Code:		Date of diagnosis:
☐	Helicobacter pylori infection	ICD Code:		Date of diagnosis:
☐	Drug-induced gastritis	ICD Code:		Date of diagnosis:
☐	Zollinger-Ellison syndrome (complete Section III and/or Section VII)	ICD Code:		Date of diagnosis:
☐	Portal-hypertensive gastropathy with varix-related complications	ICD Code:		Date of diagnosis:
☐	Postgastrectomy syndrome	ICD Code:		Date of diagnosis:
☐	Status post vagotomy with pyloroplasty	ICD Code:		Date of diagnosis:
☐	Gasteroenterostomy	ICD Code:		Date of diagnosis:
☐	Functional digestive disorder(s) (if checked complete the Intestinal Conditions questionnaire)	ICD Code:		Date of diagnosis:
☐	Gastrointestinal dysmotility disorder (if checked complete the Intestinal Conditions questionnaire)	ICD Code:		Date of diagnosis:
☐	Stomach cancer	ICD Code:		Date of diagnosis:
☐	Other stomach or duodenal conditions (specify)			
Other diagnosis #1		ICD Code:		Date of diagnosis:
Other diagnosis #2		ICD Code:		Date of diagnosis:
Other diagnosis #3		ICD Code:		Date of diagnosis:

If there are additional diagnoses that pertain to stomach or duodenum conditions, list using above format:

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 - PEPTIC ULCER DISEASE, CHRONIC GASTRITIS, OR OTHER STOMACH CONDITIONS

3A. Does the Veteran have any of the following signs or symptoms due to peptic ulcer disease, chronic gastritis, or other stomach conditions?

◯ Yes ◯ No If yes, check all that apply.

☐ History of peptic ulcer disease documented by endoscopy or diagnostic imaging studies

☐ Episodes of abdominal pain, nausea, or vomiting that last for at least three consecutive days and are managed by daily prescribed medication (select frequency)

◯ Occurring three times or less in past 12 months

◯ Occurring four or more times in past 12 months

☐ Continuous abdominal pain with intermittent vomiting

☐ Recurrent hematemesis (vomiting blood)

☐ Melena (tarry stools)

☐ Manifestations of anemia which require hospitalization at least once in the past 12 months

Date of admission: _____ Indicate facility: _____

☐ Post-operative for perforation or hemorrhage

Date of procedure(s): _____ Indicate facility: _____

If there were additional hospitalizations or procedures, list using above format:

SECTION IV - STOMACH INJURY

4A. Does the Veteran have, or has had, a stomach injury?

◯ Yes ◯ No If yes, indicate if it is post-operative or pre-operative.

◯ Post-operative (if selected, complete Section V)

◯ Pre-operative (if selected, indicate the symptoms. Check all that apply):

☐ Asymptomatic

☐ Diarrhea

☐ Constipation

☐ Colic

☐ Vomiting

☐ Nausea

☐ Abdominal pain

☐ Medically directed dietary modification other than total parenteral nutrition (TPN)

☐ Persistent partial bowel obstruction

Is the persistent partial bowel obstruction inoperable? ◯ Yes ◯ No

Is the persistent partial bowel obstruction refractory to treatment? ◯ Yes ◯ No

Does the persistent partial bowel obstruction require TPN for obstructive symptoms? ◯ Yes ◯ No

☐ Clinical evidence of recurrent obstructions requiring hospitalization at least once a year (as shown and documented in the Veteran's health record(s)).

Date of admission: _____ Indicate facility: _____

If there are additional hospitalizations, list using above format:

SECTION V - COMPLICATIONS OF UPPER GASTROINTESTINAL SURGERY AND POSTGASTRECTOMY SYNDROME

5A. Has the Veteran had upper gastrointestinal surgery performed on the stomach or duodenum?

◯ Yes ◯ No If yes, indicate the post-operative complications or residuals and check all that apply:

☐ Post-operative, asymptomatic

☐ Requiring continuous total parenteral nutrition (TPN) for a period longer than 30 consecutive days in the last six months

If checked, list dates: Start date of TPN: _____ Completion date of TPN or anticipated date of completion: _____

☐ Requiring continuous tube feedings for a period longer than 30 consecutive days in the last six months

If checked, list dates: Start date of tube feeding: _____ Completion date of tube feeding or anticipated date of completion: _____

☐ Vomiting (if checked indicate frequency and if managed by medical treatment, oral dietary modification, or medication):

Frequency:

◯ Less than 2 times a week ◯ 2 or more times a week ◯ Daily

Treatment:

◯ No treatment

◯ Managed by ongoing medical treatment

◯ Vomiting despite medical treatment (check all that apply)

☐ Oral dietary modification

☐ Medication

☐ Other (specify) _____

☐ Watery bowel movements (if checked indicate frequency):

◯ Less than 3 per day every day ◯ 3-5 per day every day ◯ 6 or more per day every day

☐ Explosive bowel movements that are difficult to predict or control

☐ Nausea (if checked indicate if managed by medical treatment):

Managed by ongoing medical treatment? ◯ Yes ◯ No

☐ Post-prandial (meal-induced) light-headedness (syncope) with sweating

☐ Requirement for medications to specifically treat complications of upper GI surgery including dumping syndrome or delayed gastric emptying

☐ Discomfort or pain within an hour of eating and requiring ongoing oral dietary modification

Other, symptom(s) specify: _____

SECTION VI - VAGOTOMY WITH PYLOROPLASTY OR GASTROENTEROSTOMY

6A. Has the Veteran had a vagotomy with pyloroplasty or gastroenterostomy?

◯ Yes ◯ No If yes, complete the following:

◯ Complete vagotomy

◯ Incomplete vagotomy

☐ Symptoms and confirmed diagnosis of alkaline gastritis (if checked also complete section III)

☐ With confirmed persisting diarrhea

☐ Following confirmation of post-operative complications of stricture or continuing gastric retention

Date of procedure(s): _____ Indicate facility: _____

If there were additional procedures, list using above format:

SECTION VII - TUMORS AND NEOPLASMS

7A. Does the Veteran currently have, or has had, a benign or malignant neoplasm or metastases related to any condition in the diagnosis section?

◯ Yes ◯ No If yes, complete the following section.

7B. Is the neoplasm

◯ Benign

◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

◯ Primary ◯ Secondary (metastatic) (if secondary, indicate the primary site, if known): _____

7C. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?

◯ Yes ◯ No; watchful waiting

If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

☐ Treatment completed

☐ Surgery

If checked, describe: _____

Date(s) of surgery: _____

☐ Radiation therapy

Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

☐ Antineoplastic chemotherapy

Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

☐ Other therapeutic procedure

If checked, describe procedure: _____

Date of most recent procedure: _____

☐ Other therapeutic treatment

If checked, describe treatment: _____

Date of completion of treatment or anticipated date of completion: _____

7D. Does the Veteran currently have any residuals or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?

◯ Yes ◯ No

If yes, list residuals or complications (brief summary), and also complete the appropriate questionnaire:

7E. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the diagnosis section, describe using the above format:

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

8A. 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)

8B. 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 the appropriate dermatological questionnaire.

SECTION IX - DIAGNOSTIC TESTING

Note: The diagnosis of peptic ulcer disease can be made by upper gastrointestinal diagnostic imaging studies or endoscopy. If testing is of record and is consistent with Veteran's current condition, repeat testing is not required.

9A. Have clinically relevant diagnostic imaging studies or other diagnostic procedures been performed or reviewed in conjunction with this examination?

◯ 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:

9B. Has clinically relevant laboratory testing been performed or reviewed in conjunction with this examination?

◯ 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: _____

_____

9C. Are there any other clinically relevant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

◯ Yes ◯ No

If yes, provide type of test or procedure, date and results (brief summary):

9D. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

SECTION X - 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.

10A. 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 XI - REMARKS

11A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION XII - 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.

12A. Examiner's signature:	12B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):
12C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	12D. Date Signed:
12E. Examiner's phone/fax numbers:	12F. National Provider Identifier (NPI) number:
12G. Medical license number and state:	
12H. Examiner's address:	