OMB Approved No. 2900-0776
Respondent Burden: 30 minutes

NON-ISCHEMIC HEART DISEASE (INCLUDING ARRHYTHMIAS AND SURGERY) DISABILITY BENEFITS QUESTIONNAIRE

NOTE - For coronary artery disease, myocardial infarction, or hypertensive disease, complete VA Form 21-0960A-1, Ischemic Heart Disease Disability Benefits Questionnaire.

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING FORM.

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

NOTE TO PHYSICIAN - Your patient 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.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE A NON-ISCHEMIC HEART DISEASE, ARRHYTHMIA, OR UNDERGONE CARDIAC SURGERY?

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

1B. Provide only diagnoses that pertain to cardiac conditions:

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1C. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO CARDIAC CONDITIONS, LIST USING ABOVE FORMAT

SECTION II - MEDICAL HISTORY

2A. DOES THE VETERAN HAVE HEART DISEASE?

☐ YES ☐ NO

(If, "Yes," check all that apply):

Diseases of the heart *(check all that apply)*

☐ Valvular heart disease ☐ Rheumatic heart disease ☐ Endocarditis

(If, checked, is there active infection with valvular heart damage?)

☐ YES ☐ NO

(If, "Yes," is the veteran currently undergoing therapy (treatment) for heart valve infection?)

☐ YES ☐ NO

(If, "No," provide date therapy ceased): __________________

(If, therapy ceased more than 3 months ago, is there any residual valvular heart disease?)

☐ YES ☐ NO

2B. DOES THE VETERAN HAVE ANY OF THE FOLLOWING CONDITIONS?

☐ Pericarditis ☐ Pericardial adhesions

(If, checked, is there active disease with pericardial involvement?) (Does this CFR category include inflammatory pericarditis?)

☐ YES ☐ NO

(If, "Yes," is the veteran currently undergoing therapy?)

☐ YES ☐ NO

(If, "No," provide date therapy ceased): __________________

☐ Syphilitic heart disease *(Note - If syphilitic aortic aneurysm is present, complete VA Form 21-0960A-2, Artery and Vein Conditions Disability Benefits Questionnaire)*

2C. DESCRIBE CAUSE/ONSET OF THE VETERAN'S HEART CONDITION *(brief summary):*

SECTION II - MEDICAL HISTORY *(Continued)*

2D. DOES THE VETERAN HAVE A CARDIAC ARRHYTHMIA?

☐ YES ☐ NO

(If, "Yes," check all that apply):

☐ Atrioventricular block *(II and III degree)* ICD CODE : ______ DATE OF DIAGNOSIS: ______

☐ Hyperthyroid heart disease ICD CODE : ______ DATE OF DIAGNOSIS: ______

☐ Supraventricular arrhythmias ICD CODE : ______ DATE OF DIAGNOSIS: ______

☐ Ventricular arrhythmias *(sustained)* ICD CODE : ______ DATE OF DIAGNOSIS: ______

(If, checked, has the veteran been admitted to a hospital?)

☐ YES ☐ NO

(If, "Yes," provide date of most recent admission): ______

☐ Other cardiac arrhythmias *(specify diagnoses):* ICD CODE : ______ DATE OF DIAGNOSIS: ______

2E. HAS THE VETERAN UNDERGONE CARDIAC SURGERY(IES)?

☐ YES ☐ NO

(If, "Yes," check all that apply):

☐ Heart valve replacement *(prosthesis)* ICD CODE : ______ DATE OF SURGERY: ______

☐ Coronary bypass surgery ICD CODE : ______ DATE OF SURGERY: ______

☐ Implantable cardiac pacemakers ICD CODE : ______ DATE OF SURGERY: ______

☐ Transplant, cardiac ICD CODE : ______ DATE OF SURGERY: ______

☐ Other cardiac surgery(ies) *(specify):* ICD CODE : ______ DATE OF SURGERY: ______

SECTION III - MEDICAL HISTORY TREATMENT

3A. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITION?

☐ YES ☐ NO

(If, "Yes," list medications):

3B. IS THERE A HISTORY OF:

☐ Percutaneous coronary intervention *(PCI)* ☐ YES ☐ NO Treatment facility/date: ______

☐ Myocardial infarction ☐ YES ☐ NO Treatment facility/date: ______

☐ Coronary bypass surgery ☐ YES ☐ NO Treatment facility/date: ______

☐ Heart transplant ☐ YES ☐ NO Treatment facility/date: ______

(If, "Yes," what condition(s) resulted in the heart transplant): ______

☐ implanted cardiac pacemaker ☐ YES ☐ NO

(If, "Yes," what condition(s) resulted in the need for a cardiac pacemaker): ______

☐ implanted automatic implantable cardioverter defibrillator *(AICD)* ☐ YES ☐ NO

(If, "Yes," what condition(s) resulted in the need for a automatic implantable cardioverter):

SECTION IV - CONGESTIVE HEART FAILURE (CHF)

4A. DOES THE VETERAN HAVE CHF?

☐ YES ☐ NO

4B. IS THE VETERAN'S CHF CHRONIC?

☐ YES ☐ NO

4C. IF THE VETERAN'S CHF IS NOT CHRONIC, HAS THE VETERAN HAD MORE THAN ONE EPISODE OF ACUTE CHF IN THE PAST YEAR?

☐ YES ☐ NO

(If, "Yes," provide the treatment facility and date of the most recent episode of CHF):

SECTION V - CARDIAC FUNCTIONAL ASSESSMENT

5A. HAS A DIAGNOSTIC EXERCISE TEST BEEN CONDUCTED?

☐ YES ☐ NO

(If "Yes," provide level of METs the veteran can perform as shown by the most recent diagnostic exercise testing): ____________________

(Date of most recent diagnostic exercise test): ____________

(If "No," complete Item 5B)

5B. COMPLETE THE FOLLOWING METs TEST BASED ON THE VETERAN'S RESPONSES:

(Lowest level of activity at which the veteran reports symptoms (check all symptoms that apply)):

☐ Dyspnea ☐ Fatigue ☐ Angina ☐ Dizziness ☐ Syncope

☐ (1-3 METs) This METs level has been found to be consistent with activities such as eating, dressing, taking a shower, slow walking (2 mph) for 1-2 blocks

☐ (>3-5 METs) This METs level has been found to be consistent with activities such as light yard work (weeding), mowing lawn (power mower), brisk walking (4 mph)

☐ (>5-7 METs) This METs level has been found to be consistent with activities such as walking 1 flight of stairs, golfing (without cart), mowing lawn (push mower), heavy yard work (digging)

☐ (>7-10 METs) This METs level has been found to be consistent with activities such as climbing stairs quickly, moderate bicycling, sawing wood, jogging (6 mph)

☐ The veteran denies experiencing above symptoms with any level of physical activity

SECTION VI - DIAGNOSTIC TESTING

NOTE - Determination of cardiac hypertrophy/dilatation is required; the suggested order of testing for cardiac hypertrophy/dilatation is EKG, then chest x-ray (PA and lateral), then echocardiogram. Echocardiogram is only necessary if the other two tests are negative. A limited echocardiogram, if available is appropriate to determine if cardiac hypertrophy/dilatation is present by measuring only left ventricular dimension, wall thickness and ejection fraction.

6A. IS THERE EVIDENCE OF CARDIAC HYPERTROPHY OR DILATATION?

☐ YES ☐ NO

6B. DIAGNOSTIC TEST *(provide most recent test only):*

☐ EKG Date of EKG: ____________

☐ Chest x-ray Date of CXR: ____________

☐ Echocardiogram Date of echocardiogram: ____________

☐ Holter monitor?

☐ YES ☐ NO

☐ Other study *(specify):* ______________________________ Date: ____________

LEFT VENTRICULAR EJECTION FRACTION (LVEF), if known: ________ % Date of test: ____________

6C. IS ATRIAL FIBRILLATION PRESENT?

☐ YES ☐ NO

(If "Yes," check all that apply)

Is it paroxysmal atrial fibrillation or other supraventricular tachycardia?

☐ YES ☐ NO

Is it permanent atrial fibrillation?

☐ YES ☐ NO

Is the frequency more than 4 episodes per year?

☐ YES ☐ NO

Is the frequency 4 or less episodes per year?

☐ YES ☐ NO

Has the frequency been documented by a Holter monitor?

☐ YES ☐ NO

Has the frequency been documented by a electrocardiogram?

☐ YES ☐ NO

SECTION VII - FUNCTIONAL IMPACT AND REMARKS

7. DOES THE VETERAN'S HEART DISEASE IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact, providing one or more examples)*

8. 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.

9A. PHYSICIAN'S SIGNATURE	9B. PHYSICIAN'S PRINTED NAME	9C. DATE SIGNED

9D. PHYSICIAN'S PHONE NUMBER	9E. PHYSICIAN'S MEDICAL LICENSE NUMBER	9F. PHYSICIAN'S ADDRESS

NOTE - VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the veteran's application.

IMPORTANT - Physician please fax the completed form to ______________________

(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at www.vba.va.gov/disabilityexams or obtained by calling 1-800-827-1000.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.