



### ESOPHAGEAL DISORDERS (INCLUDING GERD) 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

**NOTE:** The diagnosis of gastroesophageal reflux disease (GERD) can be made clinically by evidence of relief of typical symptoms of reflux, epigastric discomfort and/or burning, by treatment with proton pump inhibitors, histamine 2 receptor antagonists and/or antacids. If upper endoscopy was indicated or performed, the findings of erythema, ulcers and/or strictures are consistent with the diagnosis of GERD.

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN ESOPHAGEAL CONDITION?

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

1B. DIAGNOSIS (Check all that apply)

- |  |                 |                          |
|--|-----------------|--------------------------|
| <input type="checkbox"/> GERD  | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> HIATAL HERNIA   | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> ESOPHAGEAL STRICTURE  | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> ESOPHAGEAL SPASM  | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> ESOPHAGEAL DIVERTICULUM   | ICD CODE: _____ | DATE OF DIAGNOSIS: _____ |
| <input type="checkbox"/> OTHER ESOPHAGEAL CONDITION(S)<br>(such as eosinophilic esophagitis, Barrett's<br>esophagitis, etc.) |                 |                          |
| 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 INFECTIOUS INTESTINAL CONDITIONS, LIST USING ABOVE FORMAT:

#### SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S CURRENT ESOPHAGEAL 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 ESOPHAGEAL CONDITIONS (including GERD) ?

YES  NO

(If "Yes," check all that apply)

PERSISTENTLY RECURRENT EPIGASTRIC DISTRESS

If checked, indicate frequency 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

DYSPHAGIA

If checked, indicate frequency 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

PYROSIS (Heartburn)

If checked, indicate frequency 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

SECTION III - SIGNS AND SYMPTOMS (Continued)

REFLUX

If checked, indicate frequency 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

REGURGITATION

If checked, indicate frequency 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

SUBSTERNAL ARM OR SHOULDER PAIN

If checked, indicate frequency 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

SLEEP DISTURBANCE CAUSE BY ESOPHAGEAL REFLUX

If checked, indicate frequency 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

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 vomiting:

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 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

MELENA

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

**SECTION IV - ESOPHAGEAL STRICTURE, SPASM AND DIVERTICULA**

4. DOES THE VETERAN HAVE AN ESOPHAGEAL STRICTURE, ESOPHAGEAL SPASM NOT AMENABLE TO DILATION, OR AN ACQUIRED DIVERTICULUM OF THE ESOPHAGUS?

YES  NO

If Yes, indicate severity of condition:

ASYMPTOMATIC

MILD If checked, describe: \_\_\_\_\_

MODERATE If checked, describe: \_\_\_\_\_

SEVERE, PERMITTING PASSAGE OF LIQUIDS ONLY If checked, describe: \_\_\_\_\_

**SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, SIGNS AND/OR SYMPTOMS**

5A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS? IF YES, DESCRIBE (brief summary):

5B. 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 THE SCARS PAINFUL AND/OR UNSTABLE, OR IS THE TOTAL AREA OF ALL RELATED SCARS GREATER THAN 39 SQUARE CM (6 square inches)?

YES  NO (If yes, also complete a Scars Questionnaire)

**SECTION 6 - DIAGNOSTIC TESTING**

Note: If testing has been performed and reflects veteran's current condition, no further testing is required for this examination report.

6A. HAVE DIAGNOSTIC IMAGING STUDIES OR OTHER DIAGNOSTIC PROCEDURES BEEN PERFORMED?

YES  NO

If Yes, check all that apply:

UPPER ENDOSCOPY

Date: \_\_\_\_\_ Results: \_\_\_\_\_

UPPER GI RADIOLOGY STUDIES

Date: \_\_\_\_\_ Results: \_\_\_\_\_

ESOPHAGRAM (barium swallow)

Date: \_\_\_\_\_ Results: \_\_\_\_\_

MRI

Date: \_\_\_\_\_ Results: \_\_\_\_\_

CT

Date: \_\_\_\_\_ Results: \_\_\_\_\_

BIOPSY, SPECIFY SITE: \_\_\_\_\_

Date: \_\_\_\_\_ Results: \_\_\_\_\_

OTHER, SPECIFY: \_\_\_\_\_

Date: \_\_\_\_\_ Results: \_\_\_\_\_

6B. HAS LABORATORY TESTING BEEN PERFORMED?

YES  NO

If Yes, check all that apply:

CBC Date of testing: \_\_\_\_\_

Hemoglobin: \_\_\_\_\_ Hematocrit: \_\_\_\_\_ White blood cell count: \_\_\_\_\_ Platelets: \_\_\_\_\_

HELICOBACTER PYLORI Date of test: \_\_\_\_\_ Results: \_\_\_\_\_

OTHER, SPECIFY: \_\_\_\_\_ Date of test: \_\_\_\_\_ Results: \_\_\_\_\_

**SECTION VI - DIAGNOSTIC TESTING (Continued)**

6C. 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 VII - FUNCTIONAL IMPACT**

7. DO ANY OF THE VETERAN'S ESOPHAGEAL CONDITIONS IMPACT ON HIS OR HER ABILITY TO WORK?

YES  NO

If Yes, describe impact of each of the veteran's esophageal conditions, providing one or more examples:

8. REMARKS (*If any*)

**SECTION IX - OPTOMETRIST/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 AND FAX 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](http://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 15 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](http://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.