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Respondent Burden: 15 Minutes
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Department of Veterans Affairs

# NUTRITIONAL DEFICIENCIES 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 (First, Middle Initial, Last)

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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**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. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

## SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A NUTRITIONAL DEFICIENCY?

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

**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 appropriate date determined through record review or reported history.

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

☐ AVITAMINOSIS ICD Code: _____ Date of diagnosis: _____

☐ BERIBERI *(Vitamin B1 or thiamine deficiency)* ICD Code: _____ Date of diagnosis: _____

☐ PELLAGRA *(Vitamin B3 or niacin deficiency)* 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 NUTRITIONAL DEFICIENCIES, LIST USING ABOVE FORMAT:

**NOTE** - For all identified complications or residual conditions, ALSO complete additional questionnaires as appropriate (i.e., VA Form 21-0960F-2, Skin Disease Disability Benefits Questionnaire, VA Form 21-0960A-4, Heart Disease Disability Benefits Questionnaire and VA Form 21-0960C-10, Peripheral Nerves Disability Benefits Questionnaire)

## SECTION II - MEDICAL RECORD REVIEW

2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARATION OF THIS REPORT:

☐ C - FILE (VA ONLY)

☐ OTHER - DESCRIBE_____

## SECTION III - MEDICAL HISTORY

3A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S NUTRITIONAL DEFICIENCY CONDITION(S) *(brief summary)*:

3B. DOES THE VETERAN'S NUTRITIONAL DEFICIENCY CONDITION REQUIRE CONTINUOUS MEDICATIONS FOR CONTROL?

☐ YES ☐ NO *(If "Yes," list medications used for nutritional deficiency conditions):*

## SECTION IV - FINDINGS, SIGNS AND SYMPTOMS

4A. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO PELLAGRA OR AVITAMINOSIS?

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

- ☐ Confirmed diagnosis
- ☐ Nonspecific symptoms such as decreased appetite, weight loss, abdominal discomfort, weakness, inability to concentrate and irritability
- ☐ Stomatitis
- ☐ Achlorhydria
- ☐ Diarrhea
- ☐ Symmetrical dermatitis
- ☐ Mental symptoms
- ☐ Impaired bodily vigor
- ☐ Marked mental changes, moist dermatitis, inability to retain nourishment, exhaustion and cachexia
- ☐ Other

4B. FOR ALL CHECKED CONDITIONS IN ITEM 4A, DESCRIBE:

4C. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO BERIBERI?

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

- ☐ Peripheral neuropathy with absent knee or ankle jerks and loss of sensation
- ☐ Symptoms such as weakness, fatigue, anorexia, dizziness, heaviness and stiffness of legs, headache, or sleep disturbance
- ☐ Cardiomegaly
- ☐ Peripheral neuropathy with foot drop or atrophy of thigh or calf muscles
- ☐ Congestive heart failure, anasarca, or Wernicke-Korsakoff syndrome
- ☐ Other

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER ___ – __ – ____

## SECTION IV - FINDINGS, SIGNS AND SYMPTOMS *(Continued)*

4D. FOR ALL CHECKED CONDITIONS IN ITEM 4C, DESCRIBE:

4E. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO RESIDUALS OF BERIBERI?

☐ YES ☐ NO *(If "Yes," describe residual findings, signs and symptoms):*

4F. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO CONDITIONS OR RESIDUALS CAUSED BY ANY OTHER VITAMIN DEFICIENCY?

☐ YES ☐ NO *(If "Yes," describe):*

## SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS

5A. 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?

☐ YES ☐ NO

IF "YES," ARE ANY OF THESE SCARS PAINFUL AND/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?

☐ YES ☐ NO

IF "YES," ALSO COMPLETE VA FORM 21-0960F-1, *SCARS/DISFIGUREMENT DISABILITY BENEFITS QUESTIONNAIRE (DBQ)*.

IF "NO," PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION:_____ MEASUREMENTS: Length_____ cm X width _____ cm.

**NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in the "Remarks" section. It is not necessary to also complete a Scars/Disfigurement DBQ.**

5B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO *(If "Yes," describe (brief summary)):*

## SECTION VI - DIAGNOSTIC TESTING

**NOTE** - If testing has been completed and reflects veteran's current condition, further testing is not required.

6. ARE THERE ANY SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO *(If "Yes," describe):*

## SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S NUTRITIONAL DEFICIENCY CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact of each of the veteran's nutritional deficiency condition(s), providing one or more examples):*

## SECTION VIII - REMARKS

8. REMARKS *(If any)*

## SECTION IX - 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/FAX NUMBERS | 9E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER | 9F. PHYSICIAN'S ADDRESS |
|---|---|---|
| | | |

**NOTE** - VA may obtain 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.benefits.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, 58VA21/22/28, 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 low 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 a 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.