GALLBLADDER AND PANCREAS CONDITIONS
DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN (First, Middle Initial, Last)

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. 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 GALLBLADDER OR PANCREAS CONDITION?

YES

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

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed below. 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 is determined through record review or reported history.

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

- Chronic cholecystitis
- Chronic cholelithiasis
- Chronic cholangitis
- Cholecystectomy
- Pancreatitis
- Total or partial pancreatectomy
- Gallbladder neoplasm
- Pancreatic neoplasm
- Gallbladder or pancreas injury, with peritoneal adhesions resulting from this injury

(If checked, ALSO complete VA Form 21-0960G-6, Peritoneal Adhesions Disability Benefits Questionnaire)

Other gallbladder 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 GALLBLADDER OR PANCREAS CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S GALLBLADDER AND/OR PANCREAS CONDITION (brief summary):

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S GALLBLADDER OR PANCREAS CONDITION?

YES

NO  (If "Yes," list only those medications required for the gallbladder or pancreas condition):
SECTION III - GALLBLADDER CONDITIONS: SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY GALLBLADDER CONDITIONS OR RESIDUALS OF TREATMENT FOR GALLBLADDER CONDITIONS?

☐ YES  ☐ NO

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

☐ Gallbladder disease-induced dyspepsia (including sphincter of oddi dysfunction and/or biliary dyskinesia)
   (If checked, indicate number of episodes per year):
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

☐ Attacks of gallbladder colic
   (If checked, indicate number of attacks per year):
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

☐ Jaundice
   (If checked, provide bilirubin level in Section VI, Diagnostic Testing)

☐ Other signs or symptoms, describe:

SECTION IV - PANCREAS CONDITIONS: SIGNS AND SYMPTOMS

4A. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SYMPTOMS ATTRIBUTABLE TO ANY PANCREAS CONDITIONS OR RESIDUALS OF TREATMENT FOR PANCREAS CONDITIONS?

☐ YES  ☐ NO

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

☐ Abdominal pain, confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies
   (If checked, indicate severity and frequency of attacks, check all that apply):
   ☐ Mild (typical) ☐ Moderately Severe ☐ Severe (disabling)
   (Indicate number of attacks of MILD (TYPICAL) abdominal pain in the past 12 months):
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more
   (Indicate number of attacks of MODERATELY SEVERE abdominal pain in the past 12 months):
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more
   (Indicate number of attacks of SEVERE (DISABLING) abdominal pain in the past 12 months):
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

☐ Remissions/pain-free intermissions between attacks
   (If checked, indicate characteristics of remissions):
   ☐ Good pain-free remissions between attacks
   ☐ Few pain-free intermissions between attacks
   ☐ Continuing pancreatic insufficiency between attacks

☐ Other symptoms, describe:

4B. DOES THE VETERAN HAVE ANY OF THE FOLLOWING SIGNS OR FINDINGS ATTRIBUTABLE TO ANY PANCREAS CONDITIONS OR RESIDUALS OF TREATMENT FOR PANCREAS CONDITIONS?

☐ YES  ☐ NO

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

☐ Steatorrhea
   (If checked, describe frequency and severity):

☐ Malabsorption
   (If checked, describe frequency and severity):

☐ Diarrhea
   (If checked, describe frequency and severity):

☐ Severe malnutrition
   (If checked, describe deficiency (such as beta-carotene, fat-soluble vitamin deficiencies)):

☐ 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).
   ☐ Other:

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

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

☐ YES  ☐ NO

(If "Yes," describe in a brief summary):
### SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS (Continued)

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?

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(If "Yes," are any of the 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?)

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(If "Yes," also complete a VA Form 21-0960F-1 Scars/Disfigurement Disability Benefits Questionnaire.)

(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 below. It is not necessary to also complete a Scars DBQ.

### SECTION VI - DIAGNOSTIC TESTING

**NOTE:** Diagnosis of pancreatitis must be confirmed by appropriate laboratory and clinical studies. If testing has been performed and reflects veteran's current condition, no further testing is required for this examination report.

6A. HAVE IMAGING STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

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

- **EUS (Endoscopic ultrasound)**
  - Date: __________ Results: ____________________________
- **ERCP (Endoscopic retrograde cholangiopancreatography)**
  - Date: __________ Results: ____________________________
- **Transhepatic cholangiogram**
  - Date: __________ Results: ____________________________
- **MRI or MRCP (magnetic resonance cholangiopancreatography)**
  - Date: __________ Results: ____________________________
- **Galbladder scan (HIDA scan or cholescintigraphy)**
  - Date: __________ Results: ____________________________
- **CT**
  - Date: __________ Results: ____________________________
- **Other, specify:**
  - Date: __________ Results: ____________________________

6B. HAS LABORATORY TESTING BEEN PERFORMED?

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

- **Alkaline phosphatase**
  - Date: __________ Results: ____________________________
- **Bilirubin**
  - Date: __________ Results: ____________________________
- **WBC**
  - Date: __________ Results: ____________________________
- **Amylase**
  - Date: __________ Results: ____________________________
- **Lipase**
  - Date: __________ Results: ____________________________
- **Other, specify:**
  - Date: __________ Results: ____________________________

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

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(If "Yes," provide type of test or procedure, date and results in a brief summary):
SECTION VIII - REMARKS

8. REMARKS (If any)

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.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, 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 voluntary. 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 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.