NON-DEGENERATIVE ARTHRITIS (INCLUDING INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE AND INFECTIOUS ARTHRITIS) AND DYSBARIC OSTEONECROSIS DISABILITY BENEFITS QUESTIONNAIRE

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 listed above. (Explain your findings and reasons in comments section.)

☐ Gout

☐ Rheumatoid arthritis (atrophic)

☐ Gonorrheal arthritis

☐ Pneumococcic arthritis

☐ Typhoid arthritis

☐ Syphilitic arthritis

☐ Streptococcic arthritis

☐ Dysbaric osteonecrosis (Caisson Disease of Bone)

☐ Other (specify) (If checked, provide only diagnoses that pertain to inflammatory, autoimmune, crystalline or infectious arthritis.)

Other diagnosis #1: ICD Code: Date of diagnosis:

Other diagnosis #2: ICD Code: Date of diagnosis:

Other diagnosis #3: ICD Code: Date of diagnosis:

NOTE: These are 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 comments 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.
SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN’S INFLAMMATORY, AUTOIMMUNE, CRYSTALLINE OR INFECTIOUS ARTHRITIS OR DYSBARIC OSTEONECROSIS (brief summary):

1C. COMMENTS (if any):

1D. WAS AN OPINION REQUESTED ABOUT THIS CONDITION (internal VA only)?

☐ YES ☐ NO ☐ N/A IF YES, INCLUDE MEDICAL OPINION DBQ.

SECTION II - MEDICAL HISTORY

2B. DOES THE VETERAN REQUIRE CONTINUOUS USE OF MEDICATION FOR THE ARTHRITIS CONDITION?

☐ YES ☐ NO

IF YES, LIST ONLY THOSE MEDICATIONS USED FOR THIS ARTHRITIS:

2C. HAS THE VETERAN LOST WEIGHT DUE TO THE ARTHRITIS CONDITION?

☐ YES ☐ NO

IF YES, PROVIDE BASELINE WEIGHT (average weight for 2-year period preceding onset of disease): _________, AND CURRENT WEIGHT _________

IF YES, DOES THE VETERAN'S WEIGHT LOSS ATTRIBUTABLE TO THE ARTHRITIS CONDITION CAUSE IMPAIRMENT OF HEALTH?

☐ YES ☐ NO

IF YES, DESCRIBE THE IMPAIRMENT:

2D. DOES THE VETERAN HAVE ANEMIA DUE TO THE ARTHRITIS CONDITION?

☐ YES ☐ NO

IF YES, DOES THE VETERAN'S ANEMIA ATTRIBUTABLE TO THE ARTHRITIS CONDITION CAUSE IMPAIRMENT OF HEALTH?

☐ YES ☐ NO

IF YES, DESCRIBE THE IMPAIRMENT (also provide CBC under diagnostic testing section #9):

SECTION III - JOINT INVOLVEMENT

3A. DOES THE VETERAN HAVE PAIN (with or without joint movement) ATTRIBUTABLE TO THIS ARTHRITIS CONDITION?

☐ YES ☐ NO

IF YES, INDICATE AFFECTED JOINTS (check all that apply):

☐ CERVICAL SPINE ☐ THORACOLUMBAR SPINE ☐ SACROILIAC JOINTS

RIGHT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

LEFT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

FOR ALL CHECKED JOINTS, DESCRIBE INVOLVEMENT (brief summary):

3B. DOES THE VETERAN HAVE ANY LIMITATION OF JOINT MOVEMENT ATTRIBUTABLE TO THE ARTHRITIS CONDITION?

☐ YES ☐ NO

IF YES, INDICATE AFFECTED JOINTS (check all that apply):

☐ CERVICAL SPINE ☐ THORACOLUMBAR SPINE ☐ SACROILIAC JOINTS

RIGHT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

LEFT: ☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGERS ☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOES

FOR ALL CHECKED JOINTS, DESCRIBE LIMITATION OF MOVEMENT (brief summary):
### SECTION III - JOINT INVOLVEMENT (Continued)

3C. DOES THE VETERAN HAVE ANY JOINT DEFORMITIES ATTRIBUTABLE TO THE ARTHRITIS CONDITION?

[ ] YES  [ ] NO

If yes, indicate affected joints (check all that apply):

- [ ] CERVICAL SPINE  [ ] THORACOLUMBAR SPINE  [ ] SACROILIAC JOINTS
- [ ] RIGHT: SHOULDER  ELBOW  WRIST  HAND/FINGERS  HIP  KNEE  ANKLE  FOOT/TOES
- [ ] LEFT: SHOULDER  ELBOW  WRIST  HAND/FINGERS  HIP  KNEE  ANKLE  FOOT/TOES

For all checked joints, describe deformities (brief summary):

3D. COMMENTS (if any):

**NOTE:** For pain, limitation of joint movement and joint deformities, ALSO complete the appropriate DBQ for each affected joint, if indicated. ALSO complete the appropriate DBQ for each affected system, if indicated.

### SECTION IV - SYSTEMIC INVOLVEMENT OTHER THAN JOINTS

4A. DOES THE VETERAN HAVE ANY INVOLVEMENT OF ANY SYSTEMS, OTHER THAN JOINTS, ATTRIBUTABLE TO THIS ARTHRITIS CONDITION?

[ ] YES  [ ] NO

If yes, indicate systems involved (check all that apply):

- [ ] OPHTHALMOLOGICAL  [ ] SKIN AND MUCOUS MEMBRANES  [ ] HEMATOLOGIC  [ ] PULMONARY  [ ] CARDIAC
- [ ] NEUROLOGIC  [ ] RENAL  [ ] GASTROINTESTINAL  [ ] VASCULAR

For all checked systems, describe involvement (brief summary) (Also complete the appropriate DBQ for each affected system, if indicated):

4B. COMMENTS (if any):

### SECTION V - INCAPACITATING AND NON-INCAPACITATING EXACERBATIONS

5A. DUE TO THE ARTHRITIS CONDITION, DOES THE VETERAN HAVE EXACERBATIONS WHICH ARE NOT INCAPACITATING?

[ ] YES  [ ] NO

If yes, indicate frequency of non-incapacitating exacerbations per year:

- [ ] 0  [ ] 1  [ ] 2  [ ] 3  [ ] 4 OR MORE

Date of most recent non-incapacitating exacerbation: __________________________

Duration of most recent non-incapacitating exacerbation: __________________________

Describe non-incapacitating exacerbation: __________________________

5B. DUE TO THE ARTHRITIS CONDITION, DOES THE VETERAN HAVE EXACERBATIONS WHICH ARE INCAPACITATING?

[ ] YES  [ ] NO

If yes, indicate frequency of incapacitating exacerbations per year (on average):

- [ ] 0  [ ] 1  [ ] 2  [ ] 3  [ ] 4 OR MORE

Indicate the total duration of incapacitation over the past 12 months:

- [ ] < 1 WEEK
- [ ] 1 WEEK TO < 2 WEEKS
- [ ] 2 WEEKS TO < 4 WEEKS
- [ ] 4 WEEKS TO < 6 WEEKS
- [ ] 6 WEEKS OR MORE

Date of most recent incapacitating exacerbation: __________________________

Duration of most recent incapacitating exacerbation: __________________________

Describe incapacitating exacerbation: __________________________

5C. IS THE VETERAN'S ARTHRITIS MANIFESTED BY CONSTITUTIONAL MANIFESTATIONS ASSOCIATED WITH ACTIVE JOINT INVOLVEMENT WHICH ARE TOTALLY INCAPACITATING?

[ ] YES  [ ] NO
### SECTION V - INCAPACITATING AND NON-INCAPACITATING EXACERBATIONS (Continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>5D. Is the veteran's arthritis manifested by weight loss and anemia productive of severe impairment of health?</td>
<td></td>
<td></td>
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<tr>
<td>5E. Is the veteran's arthritis manifested by severely incapacitating exacerbations occurring 4 or more times a year or a lesser number over prolonged periods?</td>
<td></td>
<td></td>
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<tr>
<td>5F. Is the veteran's arthritis manifested by symptom combinations productive of definite impairment of health objectively supported by examination findings?</td>
<td></td>
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5G. Comments (if any):

### SECTION VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS AND SCARS

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6A. Does the veteran have any other pertinent physical findings, complications, conditions, signs or symptoms, or any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the diagnosis section above?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6B. Does the veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the diagnosis section above?</td>
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</tbody>
</table>

6C. 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, complete VA Form 21-0960F-1, Scars/Disfigurement.

**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 Comment section below. It is not necessary to also complete a Scars DBQ.

6D. Comments, if any:

### SECTION VII - ASSISTIVE DEVICES

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>7A. Does the veteran use any assistive devices as a normal mode of locomotion, although occasional locomotion by other methods may be possible?</td>
<td></td>
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</tr>
</tbody>
</table>

- Wheelchair
- Brace
- Crutches
- Cane
- Walker
- Other:

Frequency of use: Occasional, Regular, Constant

7B. If the veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition:
SECTION VIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

8. DUE TO THE VETERAN'S ARTHRITIS CONDITION, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTIONS REMAINS OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? (Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)

☐ YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROSTHESIS WOULD EQUALLY SERVE THE VETERAN.
☐ NO

IF YES, INDICATE EXTREMITIES FOR WHICH THIS APPLIES: ☐ RIGHT UPPER ☐ LEFT UPPER ☐ RIGHT LOWER ☐ LEFT LOWER

FOR EACH CHECKED EXTREMITY, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, DESCRIBE LOSS OF EFFECTIVE FUNCTION AND PROVIDE SPECIFIC EXAMPLES (brief summary):

NOTE: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prosthesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

SECTION IX - DIAGNOSTIC TESTING

NOTE: Testing listed below is not indicated for every condition.

9A. HAVE IMAGING STUDIES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, INDICATE TYPE OF STUDY:

☐ X-RAY

Area(s) imaged: ____________________________ Date: ____________ Results: ____________________________

☐ OTHER, SPECIFY: ____________________________

Area(s) imaged: ____________________________ Date: ____________ Results: ____________________________

9B. HAVE LABORATORY STUDIES BEEN PERFORMED?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

IF ANY TEST RESULTS IN THIS SECTION (Section B) ARE OTHER THAN NORMAL, INCLUDE NORMAL REFERENCE RANGES FOR YOUR FACILITY.

☐ ERYTHROCYTE SEDIMENTATION RATE (ESR)

Date of test: ____________________________ Results: ____________________________

☐ C-REACTIVE PROTEIN

Date of test: ____________________________ Results: ____________________________

☐ RHEUMATOID FACTOR (RF)

Date of test: ____________________________ Results: ____________________________

☐ ANTI-DNA ANTIBODIES

Date of test: ____________________________ Results: ____________________________

☐ ANTINUCLEAR ANTIBODIES (ANA)

Date of test: ____________________________ Results: ____________________________

☐ ANTI-CYCLIC CITRULLINATED PEPTIDE (ANTI-CCP) ANTIBODIES

Date of test: ____________________________ Results: ____________________________

☐ CBC

Hemoglobin: ____________________________ Hematocrit: ____________________________ White blood cell count: ____________________________ Platelets: ____________________________

☐ URIC ACID TEST

Date of test: ____________________________ Results: ____________________________

☐ OTHER, SPECIFY: ____________________________

Date of test: ____________________________ Results: ____________________________

9C. HAS THE VETERAN HAD A JOINT ASPIRATION OR SYNOVIAL FLUID ANALYSIS?

☐ YES ☐ NO

IF YES, INDICATE JOINT ASPIRATED, DATE AND RESULTS:

9D. HAS THE VETERAN HAD A BIOPSY (e.g., skin, nerve, fat, rectum, kidney)?

☐ YES ☐ NO

IF YES, INDICATE AREA BIOPSIED, DATE AND RESULTS:

9E. 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):

9F. IF ANY TEST RESULTS ARE OTHER THAN NORMAL, INDICATE RELATIONSHIP OF ABNORMAL FINDINGS TO DIAGNOSED CONDITIONS:
NOTE: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

10. REGARDLESS OF THE VETERAN'S CURRENT EMPLOYMENT STATUS, DO THE CONDITION(S) LISTED IN THE DIAGNOSIS SECTION IMPACT HIS OR 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:

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 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. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.