



HEART CONDITIONS (INCLUDING ISCHEMIC AND NON-ISCHEMIC HEART DISEASE, ARRHYTHMIAS, VALVULAR DISEASE AND CARDIAC 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

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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 DBQ's 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 HEART CONDITION?

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

1B. SELECT THE VETERAN'S HEART CONDITION(S) *(Check all that apply):*

- | | | |
|---|-----------------|--------------------------|
| <input type="checkbox"/> Acute, subacute, or old myocardial infarction | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Atherosclerotic cardiovascular disease | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Coronary artery disease | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Stable angina | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Unstable angina | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Coronary spasm, including Prinzmetal's angina | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Congestive heart failure | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Supraventricular arrhythmia | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Ventricular arrhythmia | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Heart block | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Valvular heart disease | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Heart valve replacement | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Cardiomyopathy | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Hypertensive heart disease | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Heart transplant | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Implanted cardiac pacemaker | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Implanted automatic implantable cardioverter defibrillator (AICD) | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Infectious heart conditions (including active valvular infection, rheumatic heart disease, endocarditis, pericarditis or syphilitic heart disease) | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Pericardial adhesions | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Other heart condition, specify below | | |
| Diagnosis #1: _____ | ICD Code: _____ | Date of diagnosis: _____ |
| Diagnosis #2: _____ | ICD Code: _____ | Date of diagnosis: _____ |

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO HEART CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S HEART CONDITION(S) *(brief summary):*

2B. DO ANY OF THE VETERAN'S HEART CONDITIONS QUALIFY WITHIN THE GENERALLY ACCEPTED MEDICAL DEFINITION OF ISCHEMIC HEART DISEASE (IHD)?

YES NO *(If "Yes," list the conditions that qualify):*

SECTION II - MEDICAL HISTORY (Continued)

2C. PROVIDE THE ETIOLOGY, IF KNOWN, OF EACH OF THE VETERAN'S HEART CONDITIONS, INCLUDING THE RELATIONSHIP/CAUSALITY TO OTHER HEART CONDITIONS, PARTICULARLY THE RELATIONSHIP/CAUSALITY TO THE VETERAN'S IHD CONDITIONS, IF ANY:

Heart condition #1 (provide etiology): _____

Heart condition #2 (provide etiology): _____

2D. IF THERE ARE ADDITIONAL HEART CONDITIONS, PROVIDE ETIOLOGY AND LIST USING THE ABOVE FORMAT:

2E. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S HEART CONDITION?

YES NO

(If, "Yes," list medications required for the veteran's heart condition (include name of medication and heart condition it is used for, such as atenolol for myocardial infarction or atrial fibrillation):

SECTION III - MYOCARDIAL INFARCTION (MI)

3A. HAS THE VETERAN HAD A MYOCARDIAL INFARCTION (MI)?

YES NO (If, "Yes," complete the following):

MI #1: Date and treatment facility: _____

MI #2: Date and treatment facility: _____

3B. IF THE VETERAN HAS HAD ADDITIONAL MIs, LIST USING ABOVE FORMAT:

SECTION IV - CONGESTIVE HEART FAILURE (CHF)

4A. HAS THE VETERAN HAD CONGESTIVE HEART FAILURE (CHF)?

YES NO (If "Yes," complete Item 4B)

4B. DOES THE VETERAN HAVE CHRONIC CHF?

YES NO

4C. HAS THE VETERAN HAD ANY EPISODES OF ACUTE CHF IN THE PAST YEAR?

YES NO

(If, "Yes," specify the number of episodes of acute CHF the veteran has had in the past year):

0 1 More than 1 Provide date of most recent episode of acute CHF: _____

4D. WAS THE VETERAN ADMITTED FOR TREATMENT OF ACUTE CHF?

YES NO (If, "Yes," indicate name of treatment facility): _____

SECTION V - ARRHYTHMIA

5A. HAS THE VETERAN HAD A CARDIAC ARRHYTHMIA?

YES NO (If "Yes," complete Item 5B)

5B. SELECT TYPE OF ARRHYTHMIA (Check all that apply):

Atrial fibrillation

(If checked, indicate frequency): Constant Intermittent (paroxysmal)

(If "Intermittent," indicate number of episodes in the past 12 months): 0 1 - 4 More than 4

(Indicate how these episodes were documented.) (Check all that apply):

EKG Holter Other, specify: _____

Atrial flutter

(If checked, indicate frequency): Constant Intermittent (paroxysmal)

(If "Intermittent," indicate number of episodes in the past 12 months): 0 1 - 4 More than 4

(Indicate how these episodes were documented.) (Check all that apply):

EKG Holter Other, specify: _____

Supraventricular tachycardia

(If checked, indicate frequency): Constant Intermittent (paroxysmal)

(If "Intermittent," indicate number of episodes in the past 12 months): 0 1 - 4 More than 4

(Indicate how these episodes were documented.) (Check all that apply):

EKG Holter Other, specify: _____

SECTION V - ARRHYTHMIA (Continued)

5B. SELECT TYPE OF ARRHYTHMIA (Check all that apply) (Continued)

Atrioventricular block I degree II degree III degree

Ventricular arrhythmia (sustained)

(Indicate date of hospital admission for initial evaluation and medical treatment in Section IX, Procedures)

Other cardiac arrhythmia, specify: _____

(If checked, indicate frequency): Constant Intermittent (paroxysmal)

(If "Intermittent," indicate number of episodes in the past 12 months): 0 1 - 4 More than 4

(Indicate how these episodes were documented.) (Check all that apply):

EKG Holter Other, specify: _____

SECTION VI - HEART VALVE CONDITIONS

6A. HAS THE VETERAN HAD A HEART VALVE CONDITION?

YES NO (If "Yes," complete Item 6B)

6B. SELECT HEART VALVES AFFECTED (Check all that apply):

Mitral Tricuspid Aortic Pulmonary

6C. DESCRIBE TYPE OF HEART VALVE CONDITION FOR EACH CHECKED VALVE:

SECTION VII - INFECTIOUS HEART CONDITIONS

7A. HAS THE VETERAN HAD ANY INFECTIOUS CARDIAC CONDITIONS, INCLUDING ACTIVE VALVULAR INFECTION (INCLUDING RHEUMATIC HEART DISEASE), ENDOCARDITIS, PERICARDITIS OR SYPHILITIC HEART DISEASE?

YES NO (If "Yes," complete Item 7B)

7B. HAS THE VETERAN UNDERGONE OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR ANY ACTIVE INFECTION?

YES NO

(If, "Yes," describe treatment and site of infection being treated):

7C. HAS TREATMENT FOR AN ACTIVE INFECTION BEEN COMPLETED?

YES NO

(If, "Yes," provide date completed): _____

7D. HAS THE VETERAN HAD A SYPHILITIC AORTIC ANEURYSM?

YES NO (If "Yes," ALSO complete VA Form 21-0960A-2, Artery and Vein Conditions Disability Benefits Questionnaire)

SECTION VIII - PERICARDIAL ADHESIONS

8A. HAS THE VETERAN HAD PERICARDIAL ADHESIONS?

YES NO (If "Yes," complete Item 8B)

8B. SELECT ETIOLOGY OF PERICARDIAL ADHESIONS:

Pericarditis Cardiac surgery/bypass Other, describe: _____

SECTION IX - PROCEDURES

9A. HAS THE VETERAN HAD ANY NON-SURGICAL OR SURGICAL PROCEDURES FOR THE TREATMENT OF A HEART CONDITION?

YES NO (If "Yes," complete Item 9B)

9B. INDICATE THE NON-SURGICAL OR SURGICAL PROCEDURES THE VETERAN HAS HAD FOR THE TREATMENT OF HEART CONDITIONS (Check all that apply):

Percutaneous coronary intervention (PCI) (angioplasty)

Indicate date of treatment or date of admission if admitted for treatment and name of treatment facility: _____

Coronary artery bypass surgery

Indicate date of admission for treatment and name of treatment facility: _____

Heart valve replacement

Specify valve(s) replaced and type of valve(s): _____

Indicate date of admission for treatment and name of treatment facility: _____

Heart transplants

Indicate date of admission for treatment and name of treatment facility: _____

Implanted cardiac pacemaker

Indicate date of admission for treatment and name of treatment facility: _____

SECTION IX - PROCEDURES (Continued)

9B. INDICATE THE NON-SURGICAL OR SURGICAL PROCEDURES THE VETERAN HAS HAD FOR THE TREATMENT OF HEART CONDITIONS (Continued)
(Check all that apply):

- Implanted automatic implantable cardioverter defibrillator (AICD)
Indicate date of admission for treatment and name of treatment facility: _____
- Valve replacement
If checked indicate valve(s) that have been replaced (check all that apply):
 Mitral Tricuspid Aortic Pulmonary
Indicate date of admission for treatment and name of treatment facility for each checked valve:

- Ventricular aneurysmectomy
Indicate date of admission for treatment and name of treatment facility: _____
- Other surgical and/or non-surgical procedures for the treatment of a heart condition, describe: _____
Indicate date of admission for treatment and name of treatment facility: _____
Indicate the condition that resulted in the need for this procedure/treatment: _____

SECTION X - HOSPITALIZATIONS

10. HAS THE VETERAN HAD ANY OTHER HOSPITALIZATIONS FOR THE TREATMENT OF HEART CONDITIONS (OTHER THAN FOR NON-SURGICAL AND SURGICAL PROCEDURES DESCRIBED ABOVE)?

- YES NO (If "Yes," provide the following):
Date of admission for treatment and name of treatment facility: _____
Condition that resulted in the need for hospitalization: _____

SECTION XI - PHYSICAL EXAM

11. PHYSICAL EXAM:

- Heart rate: _____
- Rhythm: Regular Irregular
- Point of maximal impact: Not palpable 4th intercostal space 5th intercostal space Other, specify: _____
- Heart sounds: Normal Abnormal, specify: _____
- Jugular-venous distension: Yes No
- Auscultation of the lungs: Clear Bibasilar rales Other, describe: _____
- Peripheral pulses:
- Dorsalis pedis: Normal Diminished Absent
- Posterior tibial: Normal Diminished Absent
- Peripheral edema:
- Right lower extremity: None Trace 1+ 2+ 3+ 4+
- Left lower extremity: None Trace 1+ 2+ 3+ 4+
- Blood pressure: _____

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

12A. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

- YES NO
- (If "Yes," are any of the scars painful and/or unstable, or is the total area of all related scars greater than or equal to 39 square cm (6 square inches)?)
- YES NO (If "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)

12B. 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 XIII - DIAGNOSTIC TESTING

NOTE: For VA purposes, exams for all heart conditions require a determination of whether or not cardiac hypertrophy or dilatation is present. The suggested order of testing for cardiac hypertrophy/dilatation is EKG, then chest x-ray (PA and lateral), then echocardiogram. An echocardiogram to determine heart size is only necessary if the other two tests are negative. Also for VA purposes, if LVEF testing is not of record, but available medical information sufficiently reflects the severity of the veteran's cardiovascular condition, LVEF testing is not required.

13A. IS THERE EVIDENCE OF CARDIAC HYPERTROPHY?

YES NO

(If "Yes," indicate how this condition was documented):

EKG Chest x-ray Echocardiogram Date of test: _____

13B. IS THERE EVIDENCE OF CARDIAC DILATATION?

YES NO

(If "Yes," indicate how this condition was documented):

Chest x-ray Echocardiogram Date of test: _____

13C. SELECT ALL TESTING COMPLETED AND PROVIDE MOST RECENT RESULTS WHICH REFLECT THE VETERAN'S CURRENT FUNCTIONAL STATUS

(Check all that apply):

EKG Date of EKG: _____

Result of EKG:

- Normal
- Arrhythmia, describe: _____
- Hypertrophy, describe: _____
- Ischemic, describe: _____
- Other, describe: _____

Chest x-ray Date of CXR: _____

Result of CXR:

- Normal
- Abnormal, describe: _____

Echocardiogram Date of echocardiogram: _____

Left ventricular ejection fraction (LVEF): _____ %

- Wall motion: Normal Abnormal, describe: _____
- Wall thickness: Normal Abnormal, describe: _____

Holter monitor Date of holter monitor test: _____

Result:

- Normal
- Abnormal, describe: _____

MUGA Date of MUGA: _____

Left ventricular ejection fraction (LVEF): _____ %

Result:

- Normal
- Abnormal, describe: _____

Coronary artery angiogram Date of angiogram: _____

Result:

- Normal
- Abnormal, describe: _____

CT angiography Date of CT angiography: _____

Result:

- Normal
- Abnormal, describe: _____

Other test, specify: _____ Date of test: _____

Result: _____

SECTION XIV - METs TESTING

NOTE: For VA purposes, all heart exams require METs testing (either exercise-based or interview-based) to determine the activity level at which symptoms such as dyspnea, fatigue, angina, dizziness, or syncope develop (except exams for supraventricular arrhythmias.)

If a laboratory determination of METs by exercise testing cannot be done for medical reasons (e.g. chronic CHF or multiple episodes of acute CHF within the past 12 months), or if exercise-based METs test was not completed because it is not required as part of the veteran's treatment plan, or if exercise stress test results do not reflect veteran's current cardiac function, perform an interview-based METs test based on the veteran's responses to a cardiac activity questionnaire and provide the results below.

14A. INDICATE ALL TESTING COMPLETED PROVIDING ONLY MOST RECENT RESULTS WHICH REFLECT THE VETERAN'S CURRENT FUNCTIONAL STATUS.
(Check all that apply):

Exercise stress test Date of most recent exercise stress test: _____
Results: _____
METs level the veteran performed, if provided: _____

Interview-based METs test Date of interview-based METs test: _____
Symptoms during activity:
The METs level checked below reflects the lowest activity level at which the veteran reports any of the following symptoms (check all symptoms that the veteran reports at the indicated METs level of activity):
 Dyspnea Fatigue Angina Dizziness Syncope
 Other, describe: _____

Results:
METs level on most recent interview-based METs test:
 (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

14B. IF THE VETERAN HAS HAD BOTH AN EXERCISE STRESS TEST AND INTERVIEW-BASED METs TEST, INDICATE WHICH RESULTS MOST ACCURATELY REFLECT THE VETERAN'S CURRENT CARDIAC FUNCTIONAL LEVEL:

Exercise stress test Interview-based METs test N/A

14C. IS THE METs LEVEL LIMITATION DUE SOLELY TO THE HEART CONDITIONS?

YES NO

(If "No," estimate the percentage of the METs level limitation that is due solely to the heart condition(s)):

0% 10% 20% 30% 40% 50% 60% 70% 80% 90%

The limitation in METs level is due to multiple factors; it is not possible to accurately estimate this percentage.

14D. IN ADDITION TO THE HEART CONDITION(S), DOES THE VETERAN HAVE OTHER NON-CARDIAC MEDICAL CONDITIONS (such as musculoskeletal or pulmonary conditions) LIMITING THE METs LEVEL?

YES NO

(If "Yes," identify each condition and describe how each non-cardiac medical condition limits the veteran's METs level):

Other medical condition #1: _____ Effect on METs level: _____
Other medical condition #2: _____ Effect on METs level: _____

14E. IF THERE ARE ADDITIONAL MEDICAL CONDITIONS AFFECTING METs LEVEL, LIST USING ABOVE FORMAT:

SECTION XV - FUNCTIONAL IMPACT

15. DOES THE VETERAN'S HEART CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

YES NO (If "Yes," describe impact of each of the veteran's heart conditions, providing one or more examples)

SECTION XVI - REMARKS

16. REMARKS (If any)

SECTION XVII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

17A. PHYSICIAN'S SIGNATURE

17B. PHYSICIAN'S PRINTED NAME

17C. DATE SIGNED

17D. PHYSICIAN'S PHONE AND FAX NUMBER

17E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

17F. PHYSICIAN'S ADDRESS

NOTE: VA may obtain additional medical information, including an examination, 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, 58/VA21/22/28, 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 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.