

PERSIAN GULF AND/OR AFGHANISTAN INFECTIOUS DISEASES (OTHER THAN TUBERCULOSIS) DISABILITY BENEFITS QUESTIONNAIRE

Name of Patient/Veteran	Patient/Veteran's Social Security Number Date of examination:	
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.		
questionnaire as part of their evaluation in	Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this processing the Veteran's claim. VA may obtain additional medical information, including an examination, if necessary, to plication. VA reserves the right to confirm the authenticity of ALL completed questionnaires. It is intended that this veteran's healthcare provider.	
Are you completing this Disability Benefits	s Questionnaire at the request of:	
Veteran/Claimant		
Third party (please list name(s) of or	ganization(s) or individual(s))	
Time party (please not harne(e) of si	gallization(o) of interviolation)	
Other: please describe		
Are you a VA Healthcare provider?	○ Yes ○ No	
Is the Veteran regularly seen as a patient	in your clinic? Yes No	
Was the Veteran examined in person?	Yes No	
If no, how was the examination conducted	d?	
	EVIDENCE REVIEW	
Evidence reviewed:		
No records were reviewed		
Records reviewed		
	g. service treatment records, VA treatment records, private treatment records) and the date range.	
riease identify the evidence reviewed (e.	g. Service treatment records, VA treatment records, private treatment records) and the date range.	
SECTION I - DIAGNOSIS		
1A. Does the Veteran currently have or ha	as the Veteran been diagnosed with any of the infectious diseases listed below?	
○ Yes ○ No		
If "Yes," complete item 1B		

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1B.				
Brucellosis	ICD Code:	Date of Diagnosis:		
Campylobacter jejuni	ICD Code:	Date of Diagnosis:		
Coxiella burnetii (Q fever)	ICD Code:	Date of Diagnosis:		
Malaria Malaria	ICD Code:	Date of Diagnosis:		
Nontyphoid salmonella	ICD Code:	Date of Diagnosis:		
Shigella	ICD Code:	Date of Diagnosis:		
Visceral leishmaniasis	ICD Code:	Date of Diagnosis:		
West Nile virus	ICD Code:	Date of Diagnosis:		
Mycobacterium tuberculosis (TB)*	ICD Code:	Date of Diagnosis:		
*If mycobacterium tuberculosis is the only diagnosis checked, do not complete the Questionnaire. If any other disease(s) have been checked along with mycobacter ALSO complete this questionnaire for all other non-tuberculosis related diseases	ium tuberculosis, complete the Tu	d, complete the Tuberculosis Disability Benefits iberculosis Disability Benefits Questionnaire and		
SECTION II - MEDICAL I	HISTORY FOR DISEASE #1			
2A. Name of disease #1:				
Describe history (including onset and course) of the Veteran's disease #1:				
2B. Status of disease #1: Active Inactive/treated and	resolved			
Date of cessation of treatment for active disease:				
2C. If inactive, date disease became inactive/resolved:	-			
2D. If inactive/resolved, are there residuals due to the disease?	•			
Yes No				
If yes, describe residuals:				

Note: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 38 C.F.R. 3.317(d).

SECTION III - MEDICAL HISTORY FOR DISEASE #2
3A. Name of disease #2:
Describe history (including onset and course) of the Veteran's disease #2:
3B. Status of disease #2: Active Inactive/treated and resolved
Date of cessation of treatment for active disease:
3C. If inactive, date disease became inactive/resolved:
3D. If inactive/resolved, are there residuals due to the disease?
○ Yes ○ No
If yes, describe residuals:
Note: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 38 C.F.R. 3.317(d).
SECTION IV - MEDICAL HISTORY FOR DISEASE #3
4A. Name of disease #3:
Describe history (including onset and course) of the Veteran's disease #3:

4B. Status of disease #3: Active Inactive/treated and resolved
Date of cessation of treatment for active disease:
4C. If inactive, date disease became inactive/resolved
4D. If inactive/resolved, are there residuals due to the disease?
○ Yes ○ No
If yes, describe residuals:
Note: If the Veteran has symptoms or residuals, also complete the appropriate questionnaire for each symptomatic or residual condition or disability. Potential residuals for each infectious disease are listed in the evaluation criteria in 38 C.F.R. 4.88(b) and in 38 C.F.R. 3.317(d).
SECTION V - ADDITIONAL PERSIAN GULF AND/OR AFGHANISTAN INFECTIOUS DISEASES
5A. If the Veteran has had any additional Persian Gulf and/or Afghanistan infectious diseases, describe using above format:
SECTION VI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS
6A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms related to any of the conditions listed in the diagnosis section?
○ Yes ○ No
If yes, describe (brief summary):

	Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis
section? Yes	○ No
0 163	
6C. Commer	If yes, also complete appropriate dermatological questionnaire.
6. 661111101	
	SECTION VII - DIAGNOSTIC TESTING
require speci required. (Fo	uires diagnostic confirmation for both the initial diagnosis and any relapse or recurrence. Certain Persian Gulf and/or Afghanistan infectious diseases fic testing methods to confirm recurrence of active infection. If testing has been performed and reflects Veteran's current condition, repeat testing is not rVA purposes, relapse is defined as a full return of a disease or the signs and symptoms of a disease after a period of improvement and recurrence ther separate disease episode after a full recovery has been attained).
7A. For bruce	ellosis, please state if the initial diagnosis or recurrence of active infection is confirmed by:
Culture	
Serologi	c testing
Please provid	de type of test or procedure, date and results (brief summary):
7B. For mala	ria, please state if the initial diagnosis or relapse is confirmed by:
Identific	ation of the malarial parasites in blood smears
Identifica molecula	ation of the malarial parasites in other specific diagnostic laboratory tests such as antigen detection, immunologic (immunochromatographic) tests or ar testing such as polymerase chain reaction tests
Please provid	de type of test or procedure, date and results (brief summary):
	eral leishmaniasis, please state if the recurrence of active infection is confirmed by:
Culture	
Histopat	hology
Other di	agnostic laboratory testing
Please provid	de type of test or procedure, date and results (brief summary):

	ther Persian Gulf or Afghanistan infectious diseases, plea	ase state the way in which active infection is or was
confirmed:		
Please provide type of test or procedure, date and resu	ults (brief summary):	
	SECTION VIII FUNCTIONAL IMPACT	
9A Doos the Veteran's Persian Gulf and/or Afghanista	section VIII - FUNCTIONAL IMPACT	
Yes No	n infectious disease(s) impact his or her ability to work?	
	Cult and/or Atchanistan infectious diseases arounding	and as mare examples.
ir yes, describe impact or each of the Veteran's Persian	n Gulf and/or Afghanistan infectious diseases, providing	one or more examples:
	SECTION IX - REMARKS	
9A. Remarks (if any - please identify the section to whi	ch the remark pertains when appropriate).	
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