General Medical – Separation Health Assessment
Disability Benefits Questionnaire

FIRST NAME, LAST NAME, MIDDLE NAME *(SUFFIX):*	SOCIAL SECURITY NUMBER/FILE NUMBER:	TODAY'S DATE:
HOME ADDRESS:	EXAMINING LOCATION AND ADDRESS:	
HOME TELEPHONE:		

CONTRACTOR:	VES NUMBER:	VA CLAIM NUMBER:
VES		

*****FOR NEW CONDITIONS RAISED AT THE TIME OF THE SERVICE MEMBER'S EXAM PLEASE DO NOT ADD DBQs TO FURTHER EVALUATE THESE CONDITIONS UNLESS THEY CAN BE DIAGNOSED WITHOUT FURTHER DIAGNOSTIC WORK-UP.**

PLEASE DO NOT ADD ANY DBQs TO EVALUATE STAND-ALONE HIGH CHOLESTEROL WITHOUT COMPLICATIONS; THIS IS NOT A COMPENSABLE CONDITION FOR VA RATING PURPOSES AND ONLY ITS SECONDARY COMPLICATIONS (E.G. HEART DISEASE) SHOULD BE EVALUATED IF PRESENT. ***

NOTE TO EXAMINER – The Veteran/Claimant 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 will consider the information you provide on this questionnaire as part of their evaluation in processing VA claims. Information entered here will also be shared with the Service Member's Service Department.

NOTE: This questionnaire is a screening examination for all body systems and is not meant to elicit the detailed information about specific conditions that is necessary for rating purposes. Due to the rules regarding IDES exams, please only add and complete all appropriate Disability Benefits Questionnaires for any conditions found or suspected that can be evaluated and diagnosed without further work-up or appointments. For those that would need further appointments or workup, please just describe these conditions and any relevant findings on this questionnaire.

Was a DD Form 2807-1, Report of Medical History, completed by the Service Member and available for review at the time of this examination?

☐ Yes ☐ No ☐ N/A

If yes, provide date completed:

_____

Any changes to his/her health status since DD 2807-1 completed?

☐ Yes ☐ No ☐ N/A

(Proposed) Date of separation from active service:

_____

☐ Separation date unknown

SECTION I - EVIDENCE REVIEW

***NOTE: If you reviewed the records and are unsure which option to select you may select "VA e-folder" and the QA will ensure that the correct option is selected on the final report.**

Evidence reviewed *(check all that apply)*:

☐ Not requested
☐ VA claims file (hard copy paper C-file)
☐ VA e-folder
☐ CPRS
☐ Other (please identify other evidence reviewed):

☐ No records were reviewed

Evidence comments:

☐ All available records were reviewed and findings considered when completing this DBQ.

NOTE: Selecting this option will auto-generate this statement into the Evidence Comments box in the final report for you, as well as any additional comments made below.

Additional evidence comments:

SECTION II - MEDICAL HISTORY (REVIEW OF SYSTEMS)

History of Having Symptoms Currently or in the Past: For each condition, briefly describe the history, including date of onset and course.

Please add and complete all appropriate Disability Benefits Questionnaires for any conditions found or suspected that can be evaluated and diagnosed without further workup or appointments.

2A. Head, face, neck and scalp:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2B. Nose:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2C. Sinuses:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2D. Mouth and Throat:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2E. Ears:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2F. Eyes:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2G. Heart:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2H. Lungs and Chest:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2I. Breasts:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2J. Vascular (Varicosities, hypertension, etc.):
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2K. Anus and Rectum (Hemorrhoids, Fistulae, Prostate):
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2L. Abdomen and Viscera (include Hernia):
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2M. Genitourinary:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2N. Upper Extremities:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2O. Lower Extremities:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2P. Feet:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2Q. Spine:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2R. Miscellaneous musculoskeletal conditions:
☐ Yes ☐ No

☐ Amputations

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Arthritis

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Osteoporosis/Osteopenia

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Fibromyalgia

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Muscle Injuries

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Fractures

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Other

Description of the condition/complaint	Date of onset	Course of condition/complaint

2S. Identifying body marks, scars, tattoos:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2T. Skin, Lymphatic:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2U. Neurologic:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2V. Psychiatric:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

PTSD SCREEN PC-PTSD

Post -traumatic stress disorder (PTSD) Screen = PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. In the past month, have you…

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?
☐ Yes ☐ No

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
☐ Yes ☐ No

3. been constantly on guard, watchful, or easily startled?
☐ Yes ☐ No

4. felt numb or detached from people, activities, or your surroundings?
☐ Yes ☐ No

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?
☐ Yes ☐ No

***NOTE:** Positive screen if "yes" to any three items.

DEPRESSION SCREEN

Depression screen

Over the past two weeks, how often have you been bothered by any of the following problems?

#1. Little interest or pleasure in doing things:
☐ 0 = Not at all ☐ 1 = Several days ☐ 2 = More than half the days ☐ 3 = Nearly every day

#2. Feeling down, depressed, or hopeless:
☐ 0 = Not at all ☐ 1 = Several days ☐ 2 = More than half the days ☐ 3 = Nearly every day

Total point score: _____

***NOTE:** Calculate PHQ-2 score by adding together the response value for each question, with a range of 0-6. Positive screen if score is 3 or greater.

SUICIDE RISK ASSESSMENT

Suicide Risk Assessment

Primary Screen: Over the past two weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

***NOTE:** Administer Secondary Screen (below) for any response greater than "Not at all."

Secondary Screen: Assess severity levels for suicidal ideation and suicidal behavior.

1. Over the past month, have you wished you were dead or wished you could go to sleep and not wake up?
   ☐ Yes ☐ No

2. Have you actually had any thoughts of killing yourself?
   ☐ Yes ☐ No

   *If yes to #2, continue to questions #3 through #8. If no to #2, go directly to question #7.

   3. Over the past month, have you been thinking about how you might do this?
      ☐ Yes ☐ No

   4. Over the past month, have you had these thoughts and had some intention of acting on them?
      ☐ Yes ☐ No

   5. Over the past month, have you started to work out or worked out the details of how to kill yourself?
      ☐ Yes ☐ No

      6. If the answer to question #5 is yes, ask: At any time in the past month, did you intend to carry out this plan?
         ☐ Yes ☐ No

7. In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life?
   ☐ Yes ☐ No

   8. If the answer to question #7 is yes, ask: Was this within the past three months?
      ☐ Yes ☐ No

*NOTE: Positive screen if "yes" response is given for #3, #4, #5, or #8. If there are concerns about an immediate threat, then follow appropriate emergency response procedures.

VIOLENCE/HARM RISK ASSESSMENT

Violence/Harm Risk Assessment

1. Over the past month, have you had thoughts or concerns that you might hurt or lose control with someone?
   ☐ Yes ☐ No

   *If yes, ask additional questions to determine extent of problem (target, plan, intent, past history); report findings in comment box below.

2. Does the Service Member pose a current and immediate risk to others?
   ☐ Yes ☐ No

*NOTE: Positive screen is a "yes" response to both sections. If there are concerns about an immediate threat, then follow appropriate emergency response procedures.

ALCOHOL USE SCREEN/AUDIT-C

Alcohol Use Screen Audit-C

1. How often did you have a drink containing alcohol?
   ☐ A. Never ☐ B. Monthly or less ☐ C. 2-4 times/month ☐ D. 2-3 times/week ☐ E. 4 or more times/week

2. How many drinks containing alcohol did you have on a typical day when you are drinking?
   ☐ A. 1 or 2 ☐ B. 3 or 4 ☐ C. 5 or 6 ☐ D. 7 to 9 ☐ E. 10 or more

3. For men: How often did you have six or more drinks on one occasion in the past year?
   ☐ A. Never ☐ B. Less than monthly ☐ C. Monthly ☐ D. Weekly ☐ E. Daily, or almost daily

4. For women: How often have you had four or more drinks on one occasion in the past year?
   ☐ A. Never ☐ B. Less than monthly ☐ C. Monthly ☐ D. Weekly ☐ E. Daily, or almost daily

*NOTE: Score as follows: A=0, B=1, C=2, D=3, E=4. Positive screen is five points or more.

REFERRAL FOR MENTAL HEALTH TRANSITION ASSISTANCE

NOTE: If the Service Member screens positive on a mental health screening the examiner must ensure the Service Member is aware of their mental healthcare options. At the consent of the Service Member, VA requires the examiner to refer the Service Member to the requisite transition assistance program.

NOTE TO PROVIDERS:
inTransition is a free, confidential program that offers specialized coaching and assistance for active-duty Service Members, National Guard Members, Reservists, Veterans and Retirees who need access to mental health care when…

- **Relocating to another assignment**
- **Returning from deployment**
- **Transitioning from active duty to reserve component or reserve component to active duty**
- **Preparing to leave military service**
- **…Or any other time they need a new mental health provider, or need a provider for the first time.**

STEPS FOR PROVIDERS:

1. **If the Service Member screens positive on any of the mental health screenings above, inform the Service Member of the inTransition program and ask whether they would like to participate.**
2. **If they decline, note this by choosing the appropriate option below. Otherwise, with the consent of the Service Member, and before he/she leaves the exam, call the inTransition hotline together: (800) 424-4685.**

3. Follow the prompts on the phone line to connect the Service Member with an inTransition representative.
4. If the phone call is unsuccessful:
- **a. Use the "inTransition Referral Form" in the "Forms" menu of the portal.**
- **b. Complete all fields of the form. (Note the "EDIPN ID#" is the Service Member's number on the back of his/her military ID card.)**
- **c. Upload the form to VES through the portal. Click on "My Case List," select the Service Member's name, and scroll down to the "Upload" section.**
- **d. Please add a note to the QA in the Remarks section to be on the lookout for an uploaded form.**

5. Document any challenges with contacting the inTransition hotline in the Remarks section.

1. Was the Service Member referred to the requisite transition assistance program?
☐ Yes
☐ No (Service Member did not consent)
☐ N/A (Service Member did not screen positive)

2. Comments

2W. Gynecologic: (excluding breasts):
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2X. Endocrine:
☐ Yes ☐ No

If Yes:

Description of the condition/complaint	Date of onset	Course of condition/complaint

2Y. Infectious disease, immune disorder or nutritional deficiency:
☐ Yes ☐ No

☐ Chronic Fatigue Syndrome

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ HIV and Related Illnesses

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Infectious Diseases

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Nutritional Deficiencies

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Persian Gulf and Afghanistan Infectious Diseases

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Systemic Lupus Erythematosus or Other Immune Disorders

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Tuberculosis

Description of the condition/complaint	Date of onset	Course of condition/complaint

2Z. Miscellaneous conditions:

☐ Cold Injury

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Former Prisoner of War (POW)

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Undiagnosed Illness and Unexplained Chronic Multi-Symptom Illness

Description of the condition/complaint	Date of onset	Course of condition/complaint

☐ Other

Description of the condition/complaint	Date of onset	Course of condition/complaint

SECTION III - PHYSICAL EXAM

Physical exam – Same as with Review of Systems section, please provide a brief description of any abnormal findings, as well as completing appropriate DBQ relevant to the abnormal findings on exam that can be completed without further workup or appointments.

Was a chaperone present for the physical exam of breasts, genitals and/or rectum?

☐ Yes ☐ No

If no, please provide reason:

☐ The veteran declined the genital/breast/rectal exam

☐ The veteran declined a chaperone for the exam

A chaperone was present for the breast, genital, or rectal examinations unless the presence of a chaperone was declined by the Veteran or the Veteran declined the exam.

3A. Dominant hand

☐ Right ☐ Left ☐ Ambidextrous

3B. Vital signs and labs

Blood pressure #1:	Blood pressure #2:	Blood pressure #3:

Pulse:	Respiratory rate:	Height:	Weight:

3C. Visual Acuity:

***NOTE: Can use Snellen chart or other means. May report as 20/20, or 20/"grossly normal", etc.**

Distance:

Right Eye uncorrected 20/ _____

Left Eye uncorrected 20/ _____

Right Eye corrected 20/ _____

Left Eye corrected 20/ _____

Near:

Right Eye uncorrected 20/ _____

Left Eye uncorrected 20/ _____

Right Eye corrected 20/ _____

Left Eye corrected 20/ _____

NOTE: Since this is a head-to-toe evaluation, VA will expect all body systems examined unless specifically declined by the Veteran. Please note any declined examinations in the Remarks.

1. Head, face, neck and scalp

☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

_____

_____

2. Identifying body marks, scars, tattoos

☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

_____

_____

3. Skin

☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

_____

_____

4. Nose

☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

_____

_____

5. Sinuses

☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

_____

_____

6. Mouth and throat
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

7. Dental defects and disease
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

8. Eyes - General *(Visual acuity and refraction to be completed on Eye DBQ if appropriate)*
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

If abnormal, vision and eye evaluations must be conducted by specialist.

9. Ophthalmoscopic
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

10. Pupils *(Equality and reaction)*
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

11. Ocular motility *(Associated parallel movements, nystagmus)*
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

12. Ears - External ear and canal
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

If abnormal, audio evaluations must be conducted by specialist.

13. Tympanic membranes *(Perforation)*
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

14. Heart *(Thrust, size, rhythm, sounds)*
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

15. Lungs and chest *(Include breasts)*
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

16. Vascular system *(Varicosities, etc.)*
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

17. Abdomen and viscera *(Include hernia)*
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

18. Anus and rectum *(Hemorrhoids, fistulae, prostate if indicated)*
☐ Normal ☐ Abnormal ☐ Not Examined

If abnormal:

19. Genitourinary *(Male and female)*
☐ Normal ☐ Abnormal ☐ Not Examined

If abnormal:

20. Upper extremities
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

21. Lower extremities *(Except feet)*
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

22. Feet *(Other than arch)*
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

23. Feet *(arch) (X-rays are not required to evaluate arch)*
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

24. Spine and other musculoskeletal conditions *(including ribs, clavicle, etc.)*
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

25. Lymphatic
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

26. Neurologic
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

27. Psychiatric *(Specify any personality deviation)*
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

If abnormal, mental health evaluations must be completed by specialist.

28. Pelvic and external genitalia *(Females only)*
☐ Normal ☐ Abnormal ☐ Not Examined

If abnormal:

29. Breast
☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

30. Endocrine

☐ Normal ☐ Abnormal ☐ Not examined

If abnormal:

31. Other, describe:

32. Air Conduction Threshold Audiogram

Has an audiogram been completed in the last 30 days?

☐ Yes ☐ No

If Yes, provide date completed:

If No, schedule for air conduction threshold audiogram.

***NOTE: For IDES, this section can be answered "No" if there is no complaint of hearing loss. If there is a hearing claim, answer "Yes" and then indicate "please refer to audio DBQ" in the textbox.**

RIGHT EAR

A	B	C	D	E	F	G	
500 Hz*	**1000 Hz***	**2000 Hz***	**3000 Hz***	**4000 Hz***	**6000 Hz***	**8000 Hz***	**Avg Hz (B-E)****

LEFT EAR

A	B	C	D	E	F	G	
500 Hz*	**1000 Hz***	**2000 Hz***	**3000 Hz***	**4000 Hz***	**6000 Hz***	**8000 Hz***	**Avg Hz (B-E)****

If any threshold at any frequency in either ear is abnormal, then a complete Hearing Loss and Tinnitus DBQ must be completed.

33. Tinnitus

Are you bothered by noises in your head or ears such as ringing, roaring, buzzing, crickets, or a humming tone?

☐ Yes ☐ No

If yes, are you bothered:

☐ 1. Not at all
☐ 2. Mildly bothersome *(e.g., noticed but does not interfere with daily activities)*
☐ 3. Moderately bothersome *(e.g., interferes with concentration, communication)*
☐ 4. Severely bothersome *(e.g., interferes with sleep, causes depression or anxiety)*

SECTION IV – LAB STUDIES

4A. May paste results of labs here:

SECTION V - DIAGNOSIS

☐ The Veteran does not have a current diagnosis associated with the claimed or discovered condition(s) listed above.
(This form is intended to be free standing. For each condition, or conditions found, provide associated diagnosis.)

☐ Diagnosis / diagnoses are listed on additional DBQs
(This is just a reminder to please fill out the DBQs as needed for VA rating purposes.)

Comments, if any:

List of Symptomatic Systems:
(Any time there is a "Yes" response in Medical History (Section II) the body system is listed here)

List of Abnormal Findings:
(Any time there is an "Abnormal" response in Physical Exam (Section III) the body system is listed here)

Select the additional DBQ(s) to be completed as appropriate:

☐	AUDIO HEARING LOSS & TINNITUS - 4015
☐	BONES - 2010
☐	BRAIN AND SPINAL CORD - 15010
☐	CARDIO ARTERIES & VEINS *(Vascular)* - 8035
☐	CARDIO HEART - 8016
☐	CARDIO HYPERTENSION - 8045
☐	COLD INJURY RESIDUALS - 20015
☐	DENTAL DENTAL & ORAL *(Other than TMJ)* - 18016
☐	DERM SCARS - 13015
☐	DERM SKIN - 13025
☐	ENDO DIABETES MELLITUS - 14055
☐	ENDO ENDOCRINE MISCELLANEOUS - 14015
☐	ENDO THYROID & PARATHYROID - 14025
☐	ENT EAR CONDITIONS - 4025
☐	ENT LOSS OF SENSE OF SMELL & TASTE - 5015
☐	ENT SINUSITIS, RHINITIS & OTHER ENT CONDITIONS - 7015
☐	GEN SURG HERNIA INGUINAL, FEMORAL & ABDOM *(Not hiatal)* - 9055
☐	GEN SURG RECTUM & ANUS *(Including hemorrhoids)* - 9065
☐	GENERAL MEDICAL COMPENSATION - 1016
☐	GENERAL MEDICAL PENSION - 1017
☐	GI ESOPHAGUS *(Including GERD & hiatal hernia)* - 9025

☐	GI GALLBLADDER & PANCREAS - 9045
☐	GI INTESTINES *(infectious)* - 9035
☐	GI INTESTINES *(Other than surgical or infectious)* - 9036
☐	GI INTESTINES *(Surgical)* - 9037
☐	GI LIVER CONDITIONS HEPATITIS, CIRRHOSIS & OTHER LIVER - 9046
☐	GI PERITONEAL ADHESION - 9076
☐	GI STOMACH & DUODENUM - 9075
☐	GU KIDNEY *(Nephrology)* - 10016
☐	GU MALE REPRODUCTIVE ORGAN CONDITIONS (INCLUDING PROSTATE CANCER) - 10017
☐	GU URINARY TRACT *(Bladder and urethra)* - 10018
☐	GYN BREAST CONDITIONS AND DISORDERS - 11025
☐	GYN GYNECOLOGICAL CONDITIONS - 11015
☐	HEM HEMIC & LYMPHATIC, INCLUDING LEUKEMIA - 12025
☐	INFECT HIV RELATED ILLNESS - 6025
☐	INFECT INFECTIOUS DISEASES - 6017
☐	INFECT SOUTH WEST ASIA INFECTIOUS DISEASES - 6015
☐	INFECT TUBERCULOSIS - 6016
☐	MEDICAL OPINION - 1015
☐	MUSC AMPUTATIONS - 2035
☐	MUSC ANKLE - 2045
☐	MUSC BACK *(Thoracolumbar spine)* - 2075
☐	MUSC ELBOW & FOREARM - 2046
☐	MUSC FOOT CONDITIONS, INCLUDING FLATFOOT *(Pes Planus)* - 2066
☐	MUSC HAND & FINGER - 2055
☐	MUSC HIP & THIGH - 2047
☐	MUSC KNEE & LOWER LEG - 2048
☐	MUSC MUSCLE INJURIES - 2085
☐	MUSC NECK *(Cervical spine)* - 2076
☐	MUSC OSTEOMYELITIS - 2015
☐	MUSC SHOULDER & ARM - 2049
☐	MUSC TEMPOROMANDIBULAR DISORDERS - 18015
☐	MUSC WRIST - 2044
☐	NEURO AMYOTROPHIC LATERAL SCLEROSIS - 15036
☐	NEURO CENTRAL NERVOUS SYSTEM - 15025
☐	NEURO CRANIAL NERVES - 15025
☐	NEURO DIABETIC SENSORY-MOTOR PERIPHERAL NEUROPATHY - 15015
☐	NEURO FIBROMYALGIA - 15039
☐	NEURO HEADACHES *(Including migraine headaches)* - 15037
☐	NEURO MULTIPLE SCLEROSIS - 15038
☐	NEURO NARCOLEPSY - 15055
☐	NEURO PARKINSONS DISEASE - 15035
☐	NEURO PERIPHERAL NERVES - 15045
☐	NEURO SEIZURE DISORDERS *(Epilepsy)* - 15056

☐	NEURO SPINA BIFIDA - 15016
☐	NEURO TBI INITIAL - 15065
☐	NEURO TBI REVIEW - 15066
☐	NUTRI NUTRITIONAL DEFICIENCIES - 6018
☐	OPHTH EYE - 3015
☐	PSYCH EATING DISORDERS - 16025
☐	PSYCH MENTAL DISORDERS - 16016
☐	PSYCH PTSD INITIAL - 17016
☐	PSYCH PTSD REVIEW - 16036
☐	RESP RESPIRATORY CONDITIONS - 7025
☐	RESP SLEEP APNEA - 7045
☐	RHEUM ARTHRITIS: NON-DEGEN *(Inflam, imm, cryst, infect)* - 2043
☐	RHEUM CHRONIC FATIGUE SYNDROME - 6035
☐	RHEUM SYSTEMIC LUPUS ERYTHEMATOSUS - 6019

Please enter each claimed condition and its associated diagnosis based on current exam:

Claimed Condition:	**Diagnosis:**

SECTION VI - REMARKS

6A. Remarks *(If any)*:

Is there a need for the Veteran to follow up with his/her primary care provider regarding any life threatening findings in this examination (not limited to claimed condition(s))?
☐ Yes ☐ No

If Yes, was the Veteran notified to follow up with his/her primary care provider?
☐ Yes ☐ No

Was a copy of the test result identifying the life threatening condition/findings provided to the Veteran or Veteran's primary care provider?
☐ Yes ☐ No

All additional DBQs found to be necessary completed as appropriate at time of signing this DBQ?
☐ Yes ☐ No

If No, please add the required DBQs that can be completed without further workup or appointments.

Designated VA materials regarding military sexual trauma (MST) were provided to the Veteran/Service Member:
X Yes ☐ No

***NOTE: VES provides these materials to the Veteran during the scheduling process.**

SECTION VII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

7A. PHYSICIAN'S SIGNATURE: _____

7B. PHYSICIAN'S PRINTED NAME:	
7C. DATE SIGNED:	
7D. PHYSICIAN'S PHONE/FAX NUMBERS:	1-877-637-8387 Fax: 1-800-320-3908
7E. PHYSICIAN'S NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER AND MEDICAL LICENSE NUMBER AND STATE:	
7F. PHYSICIAN'S ADDRESS:	, ,
7G. PHYSICIAN'S SPECIALTY:	