



SINUSITIS/RHINITIS AND OTHER CONDITIONS OF THE NOSE, THROAT, LARYNX AND PHARYNX DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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.

Note - The Veteran 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 may obtain additional medical information, including an examination, if necessary, to complete VA's review of the veteran's application. VA reserves the right to confirm the authenticity of ALL questionnaires completed by providers. It is intended that this questionnaire will be completed by the Veteran's provider.

Are you completing this Disability Benefits Questionnaire at the request of:

Veteran/Claimant

Other: please describe

[Text box for describing other requestor]

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?

[Text box for describing examination method]

EVIDENCE REVIEW

Evidence reviewed:

No records were reviewed

Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

[Large text box for identifying evidence reviewed]

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A SINUS, NOSE, THROAT, LARYNX OR PHARYNX CONDITION? *(This is the condition the Veteran is claiming or for which an exam has been requested.)*

YES NO

1B. IF YES, SELECT THE VETERAN'S CONDITION *(check all that apply)*

- | | | |
|---|-----------------|--------------------------|
| <input type="checkbox"/> CHRONIC SINUSITIS | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> ALLERGIC RHINITIS | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> NON-ALLERGIC RHINITIS | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> BACTERIAL RHINITIS | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> GRANULOMATOUS RHINITIS | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> CHRONIC LARYNGITIS | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> LARYNGECTOMY | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> LARYNGEAL STENOSIS | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> APHONIA | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> PHARYNGEAL INJURY <i>(Describe):</i> | ICD Code: _____ | Date of diagnosis: _____ |

- | | | |
|--|-----------------|--------------------------|
| <input type="checkbox"/> DEVIATED NASAL SEPTUM <i>(Traumatic)</i> | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> ANATOMICAL LOSS OF PART OF NOSE
<i>(Complete Scars Benefits Questionnaire in lieu of this questionnaire)</i> | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> BENIGN OR MALIGNANT NEOPLASM OF SINUS,
NOSE, THROAT, LARYNX OR PHARYNX | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> OTHER <i>(specify)</i> | | |
| 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 THE SINUSES, NOSE, THROAT, LARYNX, OR PHARYNX CONDITION(S), LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S SINUS, NOSE, THROAT, LARYNX, OR PHARYNX CONDITION:

SECTION III - NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS?

YES NO (If "No," proceed to Section IV) (If "Yes," check all that apply):

- Sinusitis (If checked, complete Part A below)
- Rhinitis (If checked, complete Part B below)
- Larynx or pharynx condition (If checked, complete Part C below)
- Deviated nasal septum (traumatic) (If checked, complete Part D below)
- Tumors or neoplasms (If checked, complete Part E below)
- Other nose, throat, larynx or pharynx conditions, pertinent physical findings or scars due to nose, throat, larynx or pharynx conditions. (If checked, complete Part F below)

PART A - SINUSITIS

A1. INDICATE THE SINUSES/TYPE OF SINUSITIS CURRENTLY AFFECTED BY THE VETERAN'S CHRONIC SINUSITIS (Check all that apply):

NONE MAXILLARY FRONTAL ETHMOID SPHENOID PANSINUSITIS

A2. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO CHRONIC SINUSITIS?

YES NO

(If "Yes," check all that apply)

- Chronic sinusitis detected only by imaging studies (See Diagnostic Testing Section)
- Episodes of sinusitis
- Near constant sinusitis (If checked, describe frequency): _____
- Headaches
- Pain of affected sinus
- Tenderness of affected sinus
- Purulent discharge
- Crusting
- Other (describe): _____

FOR ALL CHECKED CONDITIONS, DESCRIBE: _____

A3. HAS THE VETERAN HAD **NON-INCAPACITATING** EPISODES OF SINUSITIS CHARACTERIZED BY HEADACHES, PAIN AND PURULENT DISCHARGE OR CRUSTING IN THE PAST 12 MONTHS?

YES NO

(If "Yes," provide the total number of non-incapacitating episodes over the past 12 months):

1 2 3 4 5 6 7 or more

A4. HAS THE VETERAN HAD **INCAPACITATING** EPISODES OF SINUSITIS REQUIRING PROLONGED (4 to 6 weeks) OF ANTIBIOTICS TREATMENT IN THE PAST 12 MONTHS?

NOTE - For VA purposes, an incapacitating episode of sinusitis means one that requires bed rest and treatment prescribed by a physician.

YES NO

(If "Yes," provide the total number of incapacitating episodes of sinusitis requiring prolonged (4 to 6 weeks) of antibiotic treatment over the past 12 months):

1 2 3 or more

A5. HAS THE VETERAN HAD SINUS SURGERY?

YES NO

(If "Yes," specify type of surgery):

Radical (open sinus surgery) Endoscopic Other: _____

(Type of procedure, sinuses operated on and side(s)): _____

(Date(s) of surgery (if repeated sinus surgery, provide all dates of surgery)): _____

A6. IF VETERAN HAS HAD RADICAL SINUS SURGERY, DID CHRONIC OSTEOMYELITIS FOLLOW THE SURGERY?

YES NO (If "Yes," complete Osteomyelitis Questionnaire)

A7. HAS THE VETERAN HAD REPEATED SINUS-RELATED SURGICAL PROCEDURES PERFORMED?

YES NO

PART B - RHINITIS

B1. IS THERE GREATER THAN 50% OBSTRUCTION OF THE NASAL PASSAGE ON BOTH SIDES DUE TO RHINITIS?

YES NO

B2. IS THERE COMPLETE OBSTRUCTION ON THE LEFT SIDE DUE TO RHINITIS?

YES NO

B3. IS THERE COMPLETE OBSTRUCTION ON THE RIGHT SIDE DUE TO RHINITIS?

YES NO

SECTION III - NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS (Continued)

PART B - RHINITIS (Continued)

B4. IS THERE PERMANENT HYPERTROPHY OF THE NASAL TURBINATES?

YES NO

B5. ARE THERE NASAL POLYPS?

YES NO

B6. DOES THE VETERAN HAVE ANY OF THE FOLLOWING GRANULOMATOUS CONDITIONS?

YES NO (If "Yes," check all that apply)

Granulomatous rhinitis Rhinoscleroma Wegener's granulomatosis Lethal midline granuloma

Other granulomatous infection (Describe): _____

PART C - LARYNX AND PHARYNX CONDITIONS

C1. DOES THE VETERAN HAVE CHRONIC LARYNGITIS?

YES NO

(If "Yes," does the Veteran have any of the following symptoms due to chronic laryngitis?)

YES NO (If "Yes," check all that apply)

Hoarseness (If checked, describe frequency): _____

Inflammation of vocal cords

Inflammation of mucous membrane

Thickening of vocal chords

Nodules of vocal chords

Submucous infiltration of vocal chords

Vocal chord polyps

Other (describe): _____

C2. HAS THE VETERAN HAD A LARYNGECTOMY?

YES NO (If "Yes," specify)

Total laryngectomy

Partial laryngectomy

(If checked, does the Veteran have any residuals of the partial laryngectomy?)

YES NO

(If "Yes," describe): _____

C3. DOES THE VETERAN HAVE LARYNGEAL STENOSIS, INCLUDING RESIDUALS OF LARYNGEAL TRAUMA (unilateral or bilateral)?

YES NO (If "Yes," assess for upper airway obstruction with pulmonary function testing to include Flow-Volume Loop, and provide results in Diagnostic Testing Section)

C4. DOES THE VETERAN HAVE COMPLETE ORGANIC APHONIA?

YES NO (If "Yes," check all that apply)

Constant inability to speak above a whisper

Constant inability to communicate by speech

Other (describe): _____

C5. DOES THE VETERAN HAVE INCOMPLETE ORGANIC APHONIA?

YES NO (If "Yes," check all that apply)

Hoarseness (If checked, describe frequency): _____

Inflammation of vocal cords

Inflammation of mucous membrane

Thickening of vocal chords

Nodules of vocal chords

Submucous infiltration of vocal chords

Vocal chord polyps

Other (describe): _____

C6. HAS THE VETERAN HAD A PERMANENT TRACHEOSTOMY?

YES NO (If "Yes," describe reason for tracheostomy and potential for decannulation):

SECTION III - NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS (Continued)

PART C - LARYNX AND PHARYNX CONDITIONS

C7. HAS THE VETERAN HAD AN INJURY TO THE PHARYNX?

YES NO (If "Yes," check all findings, signs and symptoms that apply):

- Obstruction of the pharynx
- Obstruction of the nasopharynx
- Stricture of the pharynx
- Stricture of the nasopharynx
- Absence of the soft palate secondary to trauma
- Absence of the soft palate secondary to chemical burn
- Absence of the soft palate secondary to granulomatous disease
- Paralysis of the soft palate
- Swallowing difficulty
- Nasal regurgitation
- Speech impairment
- Other (describe): _____

C8. DOES THE VETERAN HAVE VOCAL CHORD PARALYSIS OR ANY OTHER PHARYNGEAL OR LARYNGEAL CONDITIONS?

YES NO (If "Yes," describe):

PART D - DEVIATED NASAL SEPTUM (TRAUMATIC)

D1. IS THERE AT LEAST 50% OBSTRUCTION OF THE NASAL PASSAGE ON BOTH SIDES DUE TO TRAUMATIC SEPTAL DEVIATION?

YES NO

D2. IS THE VETERAN'S DEVIATED SEPTUM TRAUMATIC?

YES NO

D3. IS THERE COMPLETE OBSTRUCTION ON LEFT SIDE DUE TO TRAUMATIC SEPTAL DEVIATION?

YES NO

D4. IS THERE COMPLETE OBSTRUCTION ON RIGHT SIDE DUE TO TRAUMATIC SEPTAL DEVIATION?

YES NO

PART E - TUMORS AND NEOPLASMS

E1. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION?

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

E2. IS THE NEOPLASM:

BENIGN MALIGNANT

E3. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

YES NO; WATCHFUL WAITING

(If "Yes," indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply)):

Treatment completed; currently in watchful waiting status

Surgery (If checked, describe): _____ (Date(s) of surgery): _____

Radiation therapy
(Date of most recent treatment): _____ (Date of completion of treatment or anticipated date of completion): _____

Antineoplastic chemotherapy
(Date of most recent treatment): _____ (Date of completion of treatment or anticipated date of completion): _____

Other therapeutic procedure (If checked, describe procedure): _____
(Date of most recent procedure): _____

Other therapeutic treatment (If checked, describe treatment): _____
(Date of completion of treatment or anticipated date of completion): _____

E4. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (including metastases) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT ABOVE?

YES NO (If "Yes," list residual conditions and complications (brief summary)):

SECTION III - NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS (Continued)

PART E - TUMORS AND NEOPLASMS (Continued)

E5. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION, DESCRIBE USING THE ABOVE FORMAT:

PART F - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

F1. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES NO

IF YES, DESCRIBE (*brief summary*):

F2. 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, ARE ANY OF THESE 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? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

YES NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION: _____ MEASUREMENTS: length _____ cm X width _____ cm.

NOTE: If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

F3. COMMENTS, IF ANY:

F4. DOES THE VETERAN HAVE LOSS OF PART OF THE NOSE OR OTHER SCARS OF THE NOSE EXPOSING BOTH NASAL PASSAGES?

YES NO

F5. DOES THE VETERAN HAVE LOSS OF PART OF THE NOSE OR OTHER SCARS CAUSING LOSS OF PART OF ONE ALA?

YES NO

F6. DOES THE VETERAN HAVE LOSS OF PART OF THE NOSE OR OTHER SCARS CAUSING ANY OTHER DISFIGUREMENT?

YES NO

SECTION IV - DIAGNOSTIC TESTING

NOTE - If testing has been performed and reflects the Veteran's current condition, repeat testing is not required. Specific diagnostic testing is not required for many conditions, but if performed, record in this section.

4A. HAVE IMAGING STUDIES OF THE SINUSES OR OTHER AREAS BEEN PERFORMED?

YES NO

(If "Yes," check all that apply)

Magnetic resonance imaging (MRI) Date: _____ Results: _____

Computed tomography (CT) Date: _____ Results: _____

X-rays: _____ Date: _____ Results: _____

Other: _____ Date: _____ Results: _____

4B. HAS ENDOSCOPY BEEN PERFORMED?

YES NO

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

Nasal endoscopy Date: _____ Results: _____

Laryngeal endoscopy Date: _____ Results: _____

Bronchoscopy Date: _____ Results: _____

Other endoscopy Date: _____ Results: _____

4C. HAS THE VETERAN HAD A BIOPSY OF THE LARYNX OR PHARYNX?

YES NO

(If "Yes," complete the following):

Site of biopsy: _____ Date: _____

Results: Benign Pre-malignant Malignant

Describe results: _____

4D. HAS THE VETERAN HAD PULMONARY FUNCTION TESTING TO ASSESS FOR UPPER AIRWAY OBSTRUCTION DUE TO LARYNGEAL STENOSIS?

YES NO

If "Yes," indicate results:

FEV-1 of 71 to 80% predicted

FEV-1 of 56 to 70% predicted

FEV-1 of 40 to 55% predicted

FEV-1 less than 40% predicted

Is the Flow-Volume Loop compatible with upper airway obstruction?

YES NO

4E. 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)):*

SECTION V - FUNCTIONAL IMPACT AND REMARKS

5A. DOES THE VETERAN'S SINUS, NOSE, THROAT, LARYNX OR PHARYNX CONDITION IMPACT HIS OR HER ABILITY TO WORK?

YES NO (If "Yes," describe impact of each of the veteran's sinus, nose, throat, larynx or pharynx conditions, providing one or more examples):

5B. REMARKS (If any)

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the application.

SECTION VI - EXAMINER'S CERTIFICATION AND SIGNATURE

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

6A. Examiner's signature:

6B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

6C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

6D. Date Signed:

6E. Examiner's phone/fax numbers:

6F. National Provider Identifier (NPI) number:

6G. Medical license number and state:

6H. Examiner's address: