SLEEP APNEA
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 Claimant/Veteran:	Claimant/Veteran's Social Security Number:	Date of Examination:
[redacted]	[redacted]	2/17/2025

Note to examiner – 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.

Is this questionnaire being completed in conjunction with a VA C&P examination request? ☒ Yes ☐ No

How was the examination completed (check all that apply)?

☒ In-person examination

☒ Records reviewed

☐ Examination via approved video telehealth

☐ Other, please specify in comments box

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

Indicate the method used to obtain medical information to complete this document:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or video telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

Evidence reviewed (check all that apply):

☐ Not requested ☐ No records were reviewed

☐ VA claims file (hard copy paper C-file)

☒ VA e-folder

☐ VA electronic health record

☐ Other, please specify in comments box

Evidence comments:

SECTION I - DIAGNOSIS

Does the Veteran have or has he or she ever had sleep apnea? ☒ Yes ☐ No

NOTE: The diagnosis of sleep apnea must be confirmed by a sleep study; provide sleep study results in Diagnostic testing section. If other respiratory condition is diagnosed, complete the Respiratory and / or Narcolepsy Questionnaire(s), in lieu of this one.

If yes, provide only diagnoses that pertain to sleep apnea and check diagnostic type:	ICD Code:	Date of diagnosis:
☒ Obstructive	G47.33	02/2021
☐ Central		
☐ Mixed, components of both		
☐ Other sleep disorder (specify):		

If there are additional diagnoses that pertain to a diagnosis of sleep apnea, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's sleep disorder condition (brief summary):

Date of Onset:
2021

Details of Onset:
Service member he had witnessed snoring, difficulty sleeping, and excessive daytime tiredness.

Course since Onset:
He underwent a sleep study that showed OSA and was given a CPAP for treatment. He continues with difficulty sleeping and excessive daytime tiredness.

2B. Is continuous medication required for control of a sleep disorder condition?

☒ Yes ☐ No (If "Yes," list only those medications required for the Veteran's sleep disorder condition):

Seroquel

2C. Does the Veteran require the use of a breathing assistance device such as a continuous positive airway pressure (CPAP) machine?

☒ Yes ☐ No

SECTION III - FINDINGS, SIGNS AND SYMPTOMS

3A. Does the Veteran currently have any findings, signs or symptoms attributable to sleep apnea?

☒ Yes ☐ No (If "Yes," check all that apply)

☒ Persistent daytime hypersomnolence
☐ Cor pulmonale
☐ Carbon dioxide retention
☐ Requires tracheostomy
☐ Chronic respiratory failure
☐ Other, describe:

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

4A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the diagnosis section above?

☐ Yes ☒ No If yes, describe (brief summary):

4B. 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?

☐ 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: 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.

4C. Comments, if any:

SECTION V - DIAGNOSTIC TESTING

Note - If diagnostic test results are in the medical record and reflect the Veteran's current sleep apnea condition, repeat testing is not required.

5A. Has a sleep study been performed?

☒ Yes ☐ No

(If yes, does the Veteran have documented sleep disorder breathing?)

☒ Yes ☐ No

Date of sleep study:

02/2021

Name of facility where sleep study performed, if known:

Home Sleep Study with Persante Sleep Care

Results:

Respiratory event index 5.8/hr with a diagnosis of OSA

5B. 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 VI - FUNCTIONAL IMPACT

6. Does the Veteran's sleep apnea impact his or her ability to work?

☒ Yes ☐ No (If "Yes," describe the impact of the Veteran's sleep apnea, providing one or more examples):

Current OR if retired/unemployed, previous occupation:
Current: Military

0-1 week work time lost in last 12 months

Service member reports symptom of excessive daytime tiredness results in difficulty completing occupational tasks.

SECTION VII - REMARKS

7. Remarks (If any)

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

Is the Veteran homeless? No

Veteran was instructed to send all personal medical records to the VA Evidence Intake Center if applicable, for proper submission into VBMS.

SECTION VIII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

8A. Examiner's signature:	8B. Examiner's printed name:	8C. Date signed:
Callie Goff Digitally Signed 02/28/2025 01:04:02 PM PA-C	Callie Goff Physician Assistant – General Practice	2/28/2025

8D. Examiner's phone/fax numbers:	8E. National Provider Identifier (NPI) number:	8F. Medical license number and state:
210-757-3172 210-757-3829	1508508284	PA15701, TX
8G. Examiner's address: 540 Oak Centre Drive Suite 101 San Antonio TX 78258		