RESPIRATORY CONDITIONS (OTHER THAN TUBERCULOSIS AND SLEEP APNEA) DISABILITY BENEFITS QUESTIONNAIRE

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

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

☒ VA e-folder

☐ No records were reviewed

☐ VA electronic health record

☐ Other, please specify in comments box

Comments:

SECTION I - DIAGNOSIS

Note: These are condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. List the claimed condition(s) that pertain to this questionnaire:

Asthma

Note: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition(s), explain your findings and reasons in the Remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis or an approximate date determined through record review or reported history.

1B. Select diagnoses associated with the claimed condition(s) (check all that apply):	ICD code:	Date of diagnosis:
☐ The Veteran does not have a current diagnosis associated with any claimed condition(s) listed above. (Explain your findings and reasons in the Remarks section)		
☒ Asthma	J45.909	01/2022
☐ Emphysema		
☐ Chronic obstructive pulmonary disease (COPD)		
☐ Chronic bronchitis		
☐ Constrictive bronchiolitis		
☐ Interstitial lung disease (if checked, specify):		

NOTE - Interstitial lung diseases include but are not limited to asbestosis, diffuse interstitial fibrosis, interstitial pneumonitis, fibrosing alveolitis, desquamative interstitial pneumonitis, pulmonary alveolar proteinosis, eosinophilic granuloma of lung, drug-induced pulmonary pneumonitis and fibrosis, radiation-induced pulmonary pneumonitis and fibrosis, hypersensitivity pneumonitis (extrinsic allergic alveolitis) and pneumoconiosis such as silicosis, anthracosis, etc.

☐	Restrictive lung disease (if checked, specify):		

NOTE - Restrictive lung diseases include but are not limited to diaphragm paralysis or paresis, spinal cord injury with respiratory insufficiency, kyphoscoliosis, pectus excavatum, pectus carinatum, traumatic chest wall defect, pneumothorax, hernia, etc., post-surgical residual (lobectomy, pneumonectomy, etc.), chronic pleural effusion or fibrosis.

☐	Mycotic lung disease (if checked, specify):		

NOTE - Mycotic lung diseases include but are not limited to histoplasmosis, blastomycosis, cryptococosis, aspergillosis, or mucomycosis.

☐	Sarcoidosis		
☐	Benign or malignant neoplasm or metastases of respiratory system (If checked, specify):		
☐	Pulmonary vascular disease (Including pulmonary thromboembolism) (If checked, specify):		
☐	Pleurisy with empyema, with or without pleurocutaneous fistula ☐ Resolved ☐ Unresolved		
☐	Other diagnosis (Specify): Other diagnosis #1: Other diagnosis #2: Other diagnosis #3:		

1C. If there are additional diagnoses that pertain to respiratory conditions, list using above format:

Note - If diagnosed with Sleep apnea and/or Narcolepsy complete the Sleep Apnea and/or Narcolepsy Questionnaire(s), in lieu of this one.

SECTION II - MEDICAL HISTORY

2A. Describe the history, including onset and course, of the Veteran's respiratory condition(s). Brief summary:

Onset Date: 2020

Details of Onset:
Service member reports this condition began during deployment, with shortness of breath. After returning in 2020, was seen by pulmonologist and was given an inhaler.

Course since Onset:
Symptoms includes shortness of breath. After an asthma exacerbation in 05/2024, he was started on Symbicort daily. Current treatment includes albuterol inhaler PRN and Symbicort inhaler twice daily.

Current Treatment:
albuterol inhaler PRN and Symbicort inhaler twice daily

2B. Does the Veteran's respiratory condition require the use of oral or parenteral corticosteroid medications?

☒ Yes ☐ No (If "Yes," complete the following):

☐ Requires chronic low dose *(*maintenance*)* corticosteroids

☒ Requires intermittent courses or bursts of systemic *(*oral or parenteral*)* corticosteroids

(If checked, indicate number of courses or bursts in past 12 months):

☐ 0 ☒ 1 ☐ 2 ☐ 3 ☐ 4 or more

☐ Requires systemic (oral or parenteral) high dose (therapeutic) corticosteroids for control

☐ Requires daily use of systemic (oral or parenteral) high dose corticosteroids

☐ Requires daily use of systemic (oral or parenteral) immuno-suppressive medications

☐ Other, describe:

(If the Veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the need for corticosteroids or immuno-suppressive medications):

2C. Does the Veteran's respiratory condition require the use of inhaled medications?

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

☒Inhalational bronchodilator therapy

(If checked, indicate frequency): ☒ Intermittent ☐ Daily

☒Inhalational anti-inflammatory medication

(If checked, indicate frequency): ☐ Intermittent ☒ Daily

☐Other inhaled medications, describe:

(If the Veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the need for inhaled medications):

2D. Does the Veteran's respiratory condition require the use of oral bronchodilators?

☐ Yes ☒ No

(If "Yes," indicate frequency): ☐ Intermittent ☐ Daily

2E. Does the Veteran's respiratory condition require the use of antibiotics?

☐ Yes ☒ No

(If "Yes," list antibiotics, dose, frequency and condition for which antibiotics are prescribed):

2F. Does the Veteran require outpatient oxygen therapy for his or her respiratory condition?

☐ Yes ☒ No

(If "Yes," does the veteran require continuous oxygen therapy (>17 hours/day)?): ☐ Yes ☐ No

(If the Veteran has more than one respiratory condition, indicate the condition which is predominantly responsible for the requirement for oxygen therapy):

SECTION III - PULMONARY CONDITIONS

3. Does the Veteran have any of the following pulmonary conditions?

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

☒	Asthma	(If checked, complete Part A below)
☐	Bronchiectasis	(If checked, complete Part B below)
☐	Sarcoidosis	(If checked, complete Part C below)
☐	Pulmonary embolism and related diseases	(If checked, complete Part D below)
☐	Bacterial lung infection	(If checked, complete Part E below)
☐	Mycotic lung infection	(If checked, complete Part F below)
☐	Pneumothorax	(If checked, complete Part G below)
☐	Gunshot/fragment wound	(If checked, complete Part H below)
☐	Cardiopulmonary complications	(If checked, complete Part I below)
☐	Respiratory failure	(If checked, complete Part J below)
☐	Tumors or neoplasms	(If checked, complete Part K below)

☐ Other pulmonary conditions, pertinent physical findings or scars due to pulmonary conditions: (If checked, complete Part L below)

PART A - ASTHMA

1A. Has the Veteran had any asthma attacks with episodes of respiratory failure in the past 12 months?

☐ Yes ☒ No

(If "Yes," indicate average number of asthma attacks with episodes of respiratory failure per week in past 12 months):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

1B. Has the Veteran had any physician visits for required care of exacerbations?

☒ Yes ☐ No

(If "yes," describe frequency and severity of exacerbations):

Mild exacerbation in 05/2024 treated with inhalers and a short course of oral steroids.

(Indicate frequency of physician visits for required care of exacerbations over past 12 months):

☒ Less frequently than monthly ☐ At least monthly

PART B - BRONCHIECTASIS

2A. Indicate any findings, signs and symptoms that are attributable to bronchiectasis

☐ Productive cough (If checked, indicate frequency and severity of productive cough (check all that apply)):

- ☐ Intermittent
- ☐ Daily
- ☐ Near constant
- ☐ Purulent sputum at times
- ☐ Blood-tinged sputum at times
- ☐ Other, describe:

☐ Acute infection

(If checked, indicate number of infections requiring a prolonged course of antibiotics (lasting 4 to 6 weeks) in the past 12 months):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

☐ Requiring a course of antibiotics at least twice a year

☐ Requiring a prolonged course of antibiotics (lasting 4 to 6 weeks) more than twice a year

☐ Requiring antibiotic usage almost continuously

☐ Anorexia

(If checked, describe):

☐ Weight loss

(If checked, provide baseline weight:

and current weight:)

(Note - For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

☐ Frank hemoptysis

(If checked, describe):

☐ Other, describe:

2B. Has the Veteran had any incapacitating episodes of infection due to bronchiectasis?

(NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician)

☐ Yes ☐ No (If "Yes," indicate total duration of incapacitating episodes of infection in past 12 months):

☐ 0 to no more than 2 weeks ☐ 2 to no more than 4 weeks ☐ 4 to no more than 6 weeks ☐ At least 6 weeks or more

PART C - SARCOIDOSIS

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

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

- ☐ No physiologic impairment
- ☐ No symptoms
- ☐ Persistent symptoms

(If checked, describe):

- ☐ Chronic hilar adenopathy
- ☐ Stable lung infiltrates
- ☐ Pulmonary involvement
- ☐ Progressive pulmonary disease

(If checked, describe):

- ☐ Cardiac involvement with congestive heart failure
- ☐ Fever

(If checked, describe):

- ☐ Night sweats

(If checked, describe):

- ☐ Weight loss

(If checked, provide baseline weight:

and current weight:)

(NOTE: For VA purposes, baseline weight is the average weight for a 2-year period preceding onset of disease)

- ☐ Other, describe:

3B. Indicate stage diagnosed by x-ray findings

☐ Stage 1: Bihilar lymphadenopathy
☐ Stage 2: Bihilar lymphadenopathy and reticulonodular infiltrates
☐ Stage 3: Bilateral pulmonary infiltrates
☐ Stage 4: Fibrocystic sarcoidosis typically with upward hilar retraction, cystic and bullous changes

3C. Does the Veteran have ophthalmologic, renal, cardiac, neurologic, or other organ system involvement due to sarcoidosis?

☐ Yes ☐ No (If "Yes," also complete appropriate additional Questionnaires)

PART D - PULMONARY EMBOLISM AND RELATED DISEASES

4. Select the statement(s) that best describe the Veteran's pulmonary vascular disease or pulmonary embolism condition (Check all that apply):

- ☐ Asymptomatic, following resolution of pulmonary thromboembolism
- ☐ Symptomatic, following resolution of acute pulmonary embolism
- ☐ Chronic pulmonary thromboembolism requiring anticoagulant therapy
- ☐ Following inferior vena cava surgery
- ☐ Chronic pulmonary thromboembolism
- ☐ Pulmonary hypertension secondary to other obstructive disease of pulmonary arteries or veins
- ☐ Other, describe:

PART E - BACTERIAL LUNG INFECTION

5A. Identify type of bacterial lung infection:

☐ Actinomycosis
☐ Nocardiosis
☐ Chronic lung abscess

☐ Other, describe:

5B. Indicate current status of the Veteran's bacterial infection of the lung

☐ Active ☐ Inactive

5C. Does the Veteran have any findings, signs and symptoms attributable to a bacterial infection of the lung or chronic lung abscess?

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

- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss

(If checked, provide baseline weight:
and current weight:)
(NOTE: For VA purposes, baseline weight is the average weight for 2-year period preceding onset of disease)

- ☐ Hemoptysis
- ☐ Other, describe:

PART F - MYCOTIC LUNG DISEASES

6. Indicate status of Mycotic lung disease (including histoplasmosis of lung, coccidoidomycosis, blastomycosis, cryptococcosis, aspergillosis, or mucormycosis)
(Check all that apply):

- ☐ No symptoms
- ☐ Chronic pulmonary mycosis
- ☐ Healed and inactive mycotic lesions
- ☐ Occasional productive cough
- ☐ Occasional minor hemoptysis
- ☐ Requires suppressive therapy
- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss

(If checked, provide baseline weight:
and current weight:)
(NOTE - For VA purposes, baseline weight is the average weight for a 2-year period preceding onset of disease)

- ☐ Massive hemoptysis
- ☐ Other, describe:

PART G - PNEUMOTHORAX

7. Indicate the type of pneumothorax, treatment and residual conditions, if any (Check all that apply):

- ☐ Spontaneous total pneumothorax
- ☐ Spontaneous partial pneumothorax
- ☐ Traumatic total pneumothorax
- ☐ Traumatic partial pneumothorax
- ☐ Resulting in hospitalization

(If checked, provide date of hospital admission:
Resulting in hospitalization date of discharge:)

- ☐ Resulting in residual conditions

Resulting in residual conditions (If checked, describe):

☐ Other, describe:

PART H - GUNSHOT/FRAGMENT WOUND

8. Select the statement(s) that best describe the Veteran's gunshot or fragment wound or the pleural cavity and residuals, if any (Check all that apply):

☐ Bullet or missile retained in lung
☐ Pain or discomfort on exertion
☐ Scattered rales
☐ Some limitation of excursion of diaphragm or of lower chest expansion
☐ Other, describe:

NOTE: If any muscles (other than those which control respiration) are affected by this injury, also complete a Muscle Injuries Questionnaire.

PART I - CARDIOPULMONARY COMPLICATIONS

9A. Does the Veteran's respiratory condition result in cardiopulmonary complications such as cor pulmonale, right ventricular hypertrophy or pulmonary hypertension?

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

☐ Cor pulmonale (right heart failure)
☐ Right ventricular hypertrophy
☐ Pulmonary hypertension (shown by echocardiogram or cardiac catheterization; report test results in Diagnosis Testing Section)
☐ Other, describe:

9B. If the Veteran has more than one respiratory condition, indicate which condition is predominantly responsible for the cardiopulmonary complications:

PART J - RESPIRATORY FAILURE

10A. Provide dates and describe the Veteran's episodes of acute respiratory failure:

10B. If the Veteran has more than one respiratory condition, indicate which condition is predominantly responsible for the episodes of respiratory failure:

PART K- TUMORS AND NEOPLASMS

11A. 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.

11B. Is the neoplasm:

☐ Benign
☐ Malignant (if malignant complete the following):

☐ Active ☐ In remission

☐ Primary ☐ Secondary (metastatic)

(if secondary, indicate the primary site, if known):

11C. 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

☐ 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:

11D. Does the Veteran currently have any residuals 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 residuals or complications (brief summary), and also complete the appropriate questionnaire:

11E. 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 L - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

12A. 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):

12B. 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.

12C. Comments, if any:

SECTION IV - DIAGNOSTIC TESTING

NOTE: If diagnostic test results are in the medical record and reflect the veteran’s current respiratory condition, repeat testing is not required.

4A. Have imaging studies or procedures been performed? (For VA purposes, imaging studies are not required for many respiratory conditions)

☐ Yes ☒ No (If “Yes,” check all that apply):

☐ Chest x-ray

Date:

Results:

☐ Magnetic resonance imaging (MRI)

Date:

Results:

☐ Computed tomography (CT)

Date:

Results:

☐ High resolution computed tomography to evaluate interstitial lung disease such as asbestosis (HRCT)

Date:

Results:

☐ Bronchoscopy

Date:

Results:

☐ Biopsy

Date:

Results:

☐ Other, describe:

Date:

Results:

4B. Has pulmonary function testing (PFT) been performed?

☒ Yes ☐ No

(If "Yes," do PFT results reported below reflect the veteran's current pulmonary function?)

☒ Yes ☐ No

Most respiratory conditions require pulmonary function testing, since PFT results represent a major basis for their evaluation. However, pulmonary function testing is not required in all instances. For VA purposes, if the Veteran has any of the following conditions, PFTs are not required. If PFTs have not been completed, indicate reason:

☐ Veteran requires outpatient oxygen therapy
☐ Veteran has had 1 or more episodes of acute respiratory failure
☐ Veteran has been diagnosed with cor pulmonale, right ventricular hypertrophy or PULMONARY hypertension
☐ Veteran has had exercise capacity testing and results are 20 ml/kg/min or less
☐ Other, describe:

4C. PFT Results:

Date of test: 02/2025

Pre-bronchodilator:			Post-bronchodilator, if indicated:		
FVC:	79	% predicted	FVC:	76	% predicted
FEV-1:	82	% predicted	FEV-1:	81	% predicted
FEV-1/FVC:	82	%	FEV-1/FVC:	84	%
DLCO:		% predicted			

4D. Which test result most accurately reflects the Veteran's level of disability (based on the condition that is being evaluated for this report)? This question is important for VA purposes.

☐ FVC % predicted ☐ FEV-1/FVC
☒ FEV-1 % predicted ☐ DLCO

4E. If post-bronchodilator testing has not been completed, indicate reason:

☐ Pre-bronchodilator results are normal
☐ Not indicated for veteran's condition
☐ Not indicated in veteran's particular case
(If checked, provide reason):
☐ Other, describe:

4F. If diffusion capacity of the lung for carbon monoxide by the single breath method (DLCO) testing has not been completed, provide reason:

☒ Not indicated for Veteran's condition
☐ Not indicated in Veteran's particular case
☐ Not valid for Veteran's particular case
☐ Other, describe:

4G. Does the Veteran have multiple respiratory conditions?

☐ Yes ☒ No

(If "Yes," list conditions and indicate which condition is predominantly responsible for the limitation in pulmonary function, if any limitation is present):

4H. Has exercise capacity testing been performed?

☐ Yes ☒ No (If "Yes," complete the following):

☐ Maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation)
☐ Maximum oxygen consumption of 15-20 ml/kg/min (with cardiorespiratory limit)
☐ Maximum oxygen consumption of more than 20 ml/kg/min
☐ Unknown results

4I. Are there any other significant diagnostic test findings and/or results?

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

SECTION V - FUNCTIONAL IMPACT

Note: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

5A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?

☒ Yes ☐ No

If yes, describe the functional impact of each condition, 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 symptoms of shortness of breath results in difficulty completing occupational tasks.

SECTION VI - REMARKS

6A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

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 VII – EXAMINER'S CERTIFICATION AND SIGNATURE

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

7A. Examiner's signature:	7B. Examiner's printed name:	7C. Date signed:
[redacted] Digitally Signed 02/28/2025 01:04:05 PM PA-C	[redacted] Physician Assistant – General Practice	2/28/2025
7D. Examiner's phone/fax numbers:	7E. National Provider Identifier (NPI) number:	7F. Medical license number and state:
[redacted]	[redacted]	Lic: # PA15701, TX

7G. Examiner's address:

540 Oak Centre Drive Suite 101 San Antonio TX 78258