Department of Veterar	ns Affairs FIBROMYA	LGIA DISABILITY BENEFITS QUESTIONNAIRE							
		<b>AY</b> OR <b>REIMBURSE</b> ANY EXPENSES OR COST INCURRED IN THE THE PRIVACY ACT AND RESPONDENT BURDEN BEFORE							
NAME OF PATIENT/VETERAN (First, Midd	le Initial, Last)								
PATIENT/VETERAN'S SOCIAL SECURITY N									
NOTE TO PHYSICIAN Vour patient is	applying to the U.S. Department of Veterang	Affairs (VA) for disability benefits. VA will consider the information you							
provide on this questionnaire as part of thei private health care providers.	r evaluation in processing the veteran's claim.	VA reserves the right to confirm the authenticity of ALL DBQs completed by							
SECTION I - DIAGNOSIS									
<b>NOTE</b> - Fibromyalgia may also be called fibrositis or primary fibromyalgia syndrome.									
1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH FIBROMYALGIA? (This is the condition the veteran is claiming or for which an exam has been requested)									
YES         NO         (If "Yes," complete	Item 1B)								
from a previous diagnosis for this condition, section. Date of diagnosis can be the date of reported history.	or if there is a diagnosis of a complication due the evaluation if the clinician is making the in	ondition(s) listed above. If there is no diagnosis, if the diagnosis is different to the claimed condition, explain your findings and reasons in the "Remarks" itial diagnosis, or an appropriate date determined through record review or							
1B. SELECT THE VETERAN'S CONDITION (	11 27								
OTHER (specify)		DATE OF DIAGNOSIS:							
OTHER DIAGNOSIS #1									
-		DATE OF DIAGNOSIS:							
OTHER DIAGNOSIS #2									
	ICD CODE:	DATE OF DIAGNOSIS:							
	SECTION II - MEDICAL RI	ECORD REVIEW							
2. INDICATE MEDICAL RECORDS REVIEW	ED IN PREPARATION OF THIS REPORT:								
$\Box C-FILE (VA ONLY)$									
OTHER (Describe):	SECTION III - MEDICA								
3A DESCRIBE THE HISTORY (including on	set and course) OF THE VETERAN'S FIBROM								
3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF FIBROMYALGIA SYMPTOMS?									
YES NO (If "Yes," list only those medications required for the veteran's fibromyalgia condition):									
3C. IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR THIS CONDITION?									
YES NO (If "Yes," describe)									
3D. ARE THE VETERAN'S FIBROMYALGIA	SYMPTOMS REFRACTORY TO THERAPY?								
YES NO (If "Yes," describe):									
	SUPERSEDES VA FOR	1 21 0060C 7 OCT 2012							

PATIENT/VETERAN'S SOCIAL SECURITY NO.								
SECTION IV - FINDINGS, SIGNS, S	SYMPTOMS							
4A. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO FIBROMYALGIA?								
$\square$ YES $\square$ NO (If "Yes," complete items 4B & 4C)								
WIDESPREAD MUSCULOSKELETAL PAIN (NOTE: For VA purposes widespread musculoskeletal pain means that pain occurs in both sides of the body, both								
above and below the waist and affecting both the axial skeleton (i.e., cervical spine, anterior chest, thoracic spine or low back) and the extremities)								
STIFFNESS								
SLEEP DISTURBANCES								
HEADACHE								
DEPRESSION								
IRRITABLE BOWEL SYMPTOMS								
RAYNAUD'S-LIKE SYMPTOMS								
OTHER (describe):								
(For all checked conditions, describe)								
<b>NOTE</b> - If Mental Health conditions, such as depression due to fibromyalgia are identified, a VA Benefits Questionnaire must ALSO be completed.	Form 21-0960P-2, Mental Disorders (Other than PTSD) Disability							
4B. FREQUENCY OF FIBROMYALGIA SYMPTOMS (check all that apply)								
PRESENT MORE THAN ONE-THIRD OF THE TIME								
OFTEN PRECIPITATED BY ENVIRONMENTAL OR EMOTIONAL STRESS OR OVEREXERT	.ON (If checkea, aescribe):							
OTHER (describe):								
4C. TENDER POINTS (trigger points) FOR PAIN (check all that apply)								
None								
All bilaterally								
Low cervical region: at anterior aspect of the interspaces between transverse processes of C5-C7 ( <i>If checked, indicate side</i> ):	Right Left Both							
Second rib: at second costochondral junction ( <i>If checked, indicate side</i> ):	Right Left Both							
Occiput: at suboccipital muscle insertion (If checked, indicate side):	Right Left Both							
Trapezius muscle: midpoint of upper border (If checked, indicate side):	Right Left Both							
Supraspinatus Muscle: above medial border of the scapular spine ( <i>If checked, indicate side</i> ):	Right Left Both							
Lateral epicondyle: 2 cm distal to lateral epicondyle ( <i>If checked, indicate side</i> ):	Right Left Both							
Gluteal: at upper outer quadrant of buttocks ( <i>If checked, indicate side</i> ):	Right Left Both							
Greater trochanter: posterior to greater trochanteric prominence ( <i>If checked, indicate side</i> ):	Right Left Both							
Knee: medial joint line (If checked, indicate side):         Other, specify:       (If checked, indicate side)	Right Left Both : Right Left Both							
SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIO 5. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATION								
CONDITIONS LISTED IN SECTION I, DIAGNOSIS?								
YES NO (If "Yes," describe - brief summary):								
SECTION VI - DIAGNOSTIC TESTING								
NOTE - If diagnostic test results are in the medical record and reflect the veteran's current condit	ion, repeat testing is not required.							
6. ARE THERE ANY SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?								
YES NO (If "Yes," provide type of test or procedure, date and results (brief summary)):								

PATIENT/VETERAN'S SOCIAL SECURITY NO.	<u> </u>	-	1_1				
PATIENT/VETERAN S SOCIAL SECORITY NO.	SI	ECTION VII	- FUI	NCTIONAL IMPACT			
7. DOES THE VETERAN'S FIBROMYALGIA IMPACT HIS OR HER ABILITY TO WORK?							
YES NO (If "Yes," describe imp	MPACT HIS OR HE	R ABILITY TO	O WOF	RK?	xamples)		
8. REMARKS (If any)							
CERTIFICATION - To the best of my 9A. PHYSICIAN'S SIGNATURE 9D. PHYSICIAN'S PHONE/FAX NUMBERS	knowledge, the ir	nformation 9B. PHYSI	conta	RTIFICATION AND S ined herein is accurat S PRINTED NAME ER (NPI) NUMBER		9C. DATE SIGNED ESS	
NOTE - VA may obtain additional medical in	formation, includir	ng additional	exami	inations if necessary to	complete VA's review of the	veteran's application.	
IMPORTANT - Physician please fax the completed form to       (VA Regional Office FAX No.)							
NOTE - A list of VA Regional Office FAX Numbers can be found at <u>www.benefits.va.gov/disabilityexams</u> or obtained by calling 1-800-827-1000.							
PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of low in effect prior to January 1, 1975, and still in effect. The requested information submitted is subject to verification through computer matching programs with other agencies. <b>RESPONDENT BURDEN:</b> We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information.							
information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete a form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at <a href="http://www.reginfo.gov/public/do/PRAMain">www.reginfo.gov/public/do/PRAMain</a> . If desired, you can call 1-800-827-1000 to							

get information on where to send comments or suggestions about this form.