OMB Approved No. 2900-0776
Respondent Burden: 15 minutes

Department of Veterans Affairs

HYPERTENSION 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 PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

NOTE TO PHYSICIAN - Your 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.

SECTION I - DIAGNOSIS

NOTE: For VA disability rating purposes, the term hypertension means that the diastolic blood pressure is predominantly 90mm or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm or greater with a diastolic blood pressure of less than 90mm. For VA purposes, the INITIAL diagnosis of hypertension or isolated systolic hypertension must be confirmed by readings taken 2 or more times on at least 3 different days. Blood pressure results may be obtained from existing medical records or through scheduled visits for blood pressure measurements.

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION BASED ON THE FOLLOWING CRITERIA?

☐ YES ☐ NO *(If "Yes," provide only diagnoses that pertain to hypertension):*

☐ Hypertension ICD Code:_____ Date of diagnosis:_____

☐ Isolated systolic hypertension ICD Code:_____ Date of diagnosis:_____

☐ Other, Specify

Other Diagnosis #1: _____ ICD Code:_____ Date of diagnosis:_____

Other Diagnosis #2: _____ ICD Code:_____ Date of diagnosis:_____

NOTE: ALSO complete appropriate questionnaires for hypertension-related complications, if any (such as VA Form 21-0960J-1, Kidney Conditions (Nephrology) Disability Benefits Questionnaire , if renal **insufficiency** is attributable to hypertension.)

1B. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (INCLUDING ONSET AND COURSE) OF THE VETERAN'S HYPERTENSION CONDITION *(Brief summary):*

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION?

☐ YES ☐ NO *(If "Yes," list only those medications used for the diagnosed conditions):*

2C. WAS THE VETERAN'S INITIAL DIAGNOSIS OF HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION CONFIRMED BY BLOOD PRESSURE READINGS TAKEN 2 OR MORE TIMES ON AT LEAST 3 DIFFERENT DAYS?

☐ YES ☐ NO ☐ UNKNOWN *(If, "Yes," provide BP readings used to establish initial diagnosis, if known.)*
(If "No," report BP readings taken 2 or more times on at least 3 different days in order to confirm diagnosis (unless veteran is on treatment for hypertension.)

READING # 1:	READING # 2:	DATE OF READING:
READING # 1:	READING # 2:	DATE OF READING:
READING # 1:	READING # 2:	DATE OF READING:

2D. DOES THE VETERAN HAVE A HISTORY OF A DIASTOLIC BP ELEVATION TO PREDOMINANTLY 100 OR MORE?

☐ YES ☐ NO *(If "Yes," describe frequency and severity of diastolic BP elevation.):*

2E. CURRENT BLOOD PRESSURE READINGS *(SUFFICIENT IF VETERAN HAS A PREVIOUSLY ESTABLISHED DIAGNOSIS OF HYPERTENSION.)*

READING # 1:	DATE OF READING:
READING # 2:	DATE OF READING:
READING # 3:	DATE OF READING:

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

3A. DOES THE VETERAN HAVE ANY SCARS (SURGICAL OR OTHERWISE) RELATED TO ANY CONDITIONS OR OT THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO *(If "Yes," complete Item 3B)*

3B. ARE ANY OF THE SCARS PAINFUL AND/OR UNSTABLE, OR IS THE TOTAL AREA OF ALL RELATED SCARS 39 SQUARE CM *(6 SQUARE INCHES)* OR GREATER?

☐ YES ☐ NO *(If "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)*

3C. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITION(S) LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO *(If "Yes," describe-brief summary)*

SECTION IV - FUNCTIONAL IMPACT

4. DOES THE VETERAN'S HYPERTENSION OR ISOLATED SYSTOLIC HYPERTENSION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of the veteran's hypertension or isolated systolic hypertension, providing one or more examples):*

SECTION V - REMARKS

5. REMARKS *(If any)*

SECTION VI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

6A. PHYSICIAN'S SIGNATURE	6B. PHYSICIAN'S PRINTED NAME	6C. DATE SIGNED

6D. PHYSICIAN'S PHONE AND FAX NUMBER	6E. PHYSICIAN'S MEDICAL LICENSE NUMBER	6F. PHYSICIAN'S ADDRESS

NOTE - VA may request additional medical information, including additional examinations, 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 www.vba.va.gov/disabilityexams 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, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. 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 law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: 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. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete the 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 www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.