



RECTUM AND ANUS CONDITIONS (INCLUDING HEMORRHOIDS) 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

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER HAD ANY CONDITION OF THE RECTUM OR ANUS?

YES NO (If "Yes," complete Item 1B)

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

- | | | |
|---|-----------------|--------------------------|
| <input type="checkbox"/> Internal or external hemorrhoids | ICD code: _____ | Date of diagnoses: _____ |
| <input type="checkbox"/> Anal/perianal fistula | ICD code: _____ | Date of diagnoses: _____ |
| <input type="checkbox"/> Rectal stricture | ICD code: _____ | Date of diagnoses: _____ |
| <input type="checkbox"/> Impairment of rectal sphincter control | ICD code: _____ | Date of diagnoses: _____ |
| <input type="checkbox"/> Rectal prolapse | ICD code: _____ | Date of diagnoses: _____ |
| <input type="checkbox"/> Pruritus ani | ICD code: _____ | Date of diagnoses: _____ |
| <input type="checkbox"/> Other, specify below: | | |
| Other diagnoses #1: _____ | ICD code: _____ | Date of diagnoses: _____ |
| Other diagnoses #2: _____ | ICD code: _____ | Date of diagnoses: _____ |

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO RECTUM OR ANUS CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (*including onset and course*) OF THE VETERAN'S RECTUM OR ANUS CONDITIONS (*brief summary*):

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITIONS?

YES NO

IF YES, LIST ONLY THOSE MEDICATIONS USED FOR THE DIAGNOSED CONDITIONS: _____

SECTION III - SIGNS AND SYMPTOMS

3. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO ANY OF THE DIAGNOSES IN SECTION 1, DIAGNOSIS?

YES NO IF YES, SPECIFY THE CONDITIONS BELOW AND COMPLETE THE APPROPRIATE SECTIONS.

INTERNAL OR EXTERNAL HEMORRHOIDS

IF CHECKED, INDICATE SEVERITY (*check all that apply*):

Mild or moderate

If checked, describe: _____

Large or thrombotic, irreducible, with excessive redundant tissue, evidencing frequent recurrences

With persistent bleeding

With secondary anemia

If checked, provide hemoglobin/hematocrit in Section VI, Diagnostic Testing

With fissures

Other, describe: _____

ANAL/PERIANAL FISTULA

IF CHECKED, INDICATE SEVERITY (*check all that apply*):

Slight impairment of sphincter control, without leakage

If checked, describe: _____

Leakage necessitates wearing of pad

Constant slight leakage

Occasional moderate leakage

Occasional involuntary bowel movements

SECTION III - SYMPTOMS OF RECTUM OR ANUS CONDITION(S) (Continued)

- Extensive leakage
- Fairly frequent involuntary bowel movements
- Complete loss of sphincter control
- Other, describe: _____

RECTAL STRICTURE

IF CHECKED, INDICATE SEVERITY (*check all that apply*):

- Moderate reduction of lumen
- Great reduction of lumen
- Moderate constant leakage
- Extensive leakage
- Requiring colostomy (*which is present*)
- Other, describe: _____

IMPAIRMENT OF RECTAL SPHINCTER CONTROL

IF CHECKED, INDICATE SEVERITY (*check all that apply*):

- Slight impairment of sphincter control, without leakage
If checked, describe: _____
- Leakage necessitates wearing of pad
- Constant slight leakage
- Occasional moderate leakage
- Occasional involuntary bowel movements
- Extensive leakage
- Fairly frequent involuntary bowel movements
- Complete loss of sphincter control
- Other, describe: _____

RECTAL PROLAPSE

IF CHECKED, INDICATE SEVERITY (*check all that apply*):

- Mild with constant slight or occasional moderate leakage
- Moderate, persistent or frequently recurring
- Severe (*or complete*), persistent
- Other, describe: _____

PRURITUS ANI

IF CHECKED, INDICATE UNDERLYING CONDITION AND DESCRIBE: _____

(If appropriate complete a questionnaire for each underlying condition, such as VA Form 21-0960F-2, Skin Diseases Disability Benefits Questionnaire)

SECTION IV - EXAM

4. PROVIDE RESULTS OF EXAMINATION OF RECTAL/ANAL AREA (*check all that apply*):

- No exam performed for this condition; provide reason: _____
- Normal; no external hemorrhoids, anal fissures or other abnormalities
- No external hemorrhoids; skin tags only
- Small or moderate external hemorrhoids
- Large external hemorrhoids
- Thrombotic external hemorrhoids
- Reducible external hemorrhoids
- Irreducible external hemorrhoids
- Excessive redundant tissue
- Anal fissure(s)
If checked, describe: _____
- Other, describe: _____

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

5A. DOES THE VETERAN HAVE ANY SCARS (*surgical or otherwise*) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

- YES NO

IF YES, ARE ANY OF THE SCARS PAINFUL AND/OR UNSTABLE, OR IS THE TOTAL AREA OF ALL RELATED SCARS GREATER THAN 39 SQUARE CM (6 square inches)?

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

SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS (Continued)

5B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION 1, DIAGNOSIS?

 YES NOIF YES, DESCRIBE (*brief summary*):**SECTION VI - DIAGNOSTIC TESTING****NOTE** - If imaging studies, diagnostic procedures or laboratory testing have been performed and reflect the veteran's current condition, no further testing is required for this examination report.

6A. HAS LABORATORY TESTING BEEN PERFORMED?

 YES NO

IF YES, CHECK ALL THAT APPLY:

 CBC (*if anemia due to any intestinal condition is suspected or present*) Date of test: _____

Hemoglobin: _____ Hematocrit: _____ White blood cell count: _____ Platelets: _____

 Other, specify: _____ Date of test: _____ Results: _____

6B. HAVE IMAGING STUDIES OR DIAGNOSTIC PROCEDURES BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

 YES NOIF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS (*brief summary*):

6C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

 YES NOIF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS (*brief summary*):**SECTION VII - FUNCTIONAL IMPACT**

7. DOES THE VETERAN'S RECTUM OR ANUS CONDITION IMPACT HIS OR HER ABILITY TO WORK?

 YES NO (*If "Yes," describe the impact of each of the veteran's rectum or anus conditions, providing one or more examples:*)**SECTION VIII - REMARKS**8. REMARKS (*If any*)**SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE****CERTIFICATION** - To the best of my knowledge, the information contained herein is accurate, complete and current.

9A. PHYSICIAN'S SIGNATURE

9B. PHYSICIAN'S PRINTED NAME

9C. DATE SIGNED

9D. PHYSICIAN'S PHONE AND FAX NUMBER

9E. PHYSICIAN'S MEDICAL LICENSE NUMBER

9F. 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.