



ISCHEMIC HEART DISEASE (IHD) 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 ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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NOTE TO PHYSICIAN - Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will use the information you provide on this questionnaire to process the Veteran's claim. VA reserves the right to confirm the authenticity of ALL DBQ's completed by private health care providers.

SECTION I - DIAGNOSIS

NOTE: IHD includes, but is not limited to, acute, sub-acute and old myocardial infarction; atherosclerotic cardiovascular disease including coronary artery disease (including coronary spasm) and coronary bypass surgery; and stable, unstable and Prinzmetal's angina. IHD does not include hypertension or peripheral manifestations of arteriosclerosis such as peripheral vascular disease or stroke, or any other condition that does not qualify within the generally accepted medical definition of ischemic heart disease.

IHD encompasses any atherosclerotic heart disease resulting in clinically significant ischemia or requiring coronary revascularization.

1A. DOES THE VETERAN HAVE ISCHEMIC HEART DISEASE (IHD)?

YES NO

NOTE: Provide only diagnoses that pertain to IHD

1B. DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
1C. DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
1D. DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1E. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO IHD, LIST USING ABOVE FORMAT

SECTION II - MEDICAL HISTORY

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

YES NO

2B. LIST MEDICATIONS PRESCRIBED FOR IHD-RELATED CONDITIONS:

2C. IS THERE A HISTORY OF: *(Check all that apply and provide treatment facility and treatment date)*

CONDITION	YES (Check)	NO (Check)	TREATMENT FACILITY	DATE OF TREATMENT
PERCUTANEOUS CORONARY INTERVENTION (PCI)				
MYOCARDIAL INFARCTION				
CORONARY BYPASS SURGERY				
HEART TRANSPLANT <i>(If "Yes," is it as likely as not that the veteran's heart transplant is due to IHD?)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO				
IMPLANTED CARDIAC PACEMAKER <i>(If "Yes," is it as likely as not that the veteran's pacemaker is due to IHD?)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO				
IMPLANTED AUTOMATIC IMPLANTABLE CARDIOVERTER DEFIBRILLATOR (AICD) <i>(If "Yes," is it as likely as not that the veteran's AICD is due to IHD?)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO				

SECTION III - CONGESTIVE HEART FAILURE (CHF)

3A. DOES THE VETERAN HAVE CHF? YES NO

3B. IS THE VETERAN'S CHF CHRONIC? YES NO

SECTION III - CONGESTIVE HEART FAILURE (CHF) (Continued)

3C. IF THE VETERAN'S CHF IS NOT CHRONIC, HAS THE VETERAN HAD MORE THAN ONE EPISODE OF ACUTE CHF IN THE PAST YEAR? YES NO
 If "Yes," provide name of treatment facility: _____
 Date of most recent episode of CHF: _____

SECTION IV - CARDIAC FUNCTIONAL ASSESSMENT

4A. HAS A DIAGNOSTIC EXERCISE TEST BEEN CONDUCTED? YES NO
 If "Yes," provide level of METS the veteran can perform as shown by diagnostic exercise testing: _____
 Date of most recent test: _____

4B. IF EXERCISE METs TESTING WAS NOT COMPLETED BECAUSE IT IS NOT REQUIRED AS PART OF THE VETERAN'S TREATMENT PLAN, COMPLETE THE FOLLOWING METs TEST BASED ON THE VETERAN'S RESPONSES:

Lowest level of activity at which veteran reports symptoms (Check all symptoms that apply)

- DYSPNEA FATIGUE ANGINA DIZZINESS SYNCOPE

This METs Level has been found to be consistent with activities such as:

- 1-3 METs** (This METs level has been found to be consistent with activities such as eating, dressing, taking a shower, slow walking (2 mph) for 1-2 blocks) **>7-10 METs** (This METs level has been found to be consistent with activities such as climbing stairs quickly, moderate bicycling, sawing wood, jogging (6 mph))
- >3-5 METs** (This METs level has been found to be consistent with activities such as light yard work (weeding), mowing lawn (power mower), brisk walking (4 mph)) Veteran denies experiencing above symptoms with any level of physical activity
- >5-7 METs** (This METs level has been found to be consistent with activities such as golfing (without cart), mowing lawn (push mower), heavy yard work (digging))

SECTION V - DIAGNOSTIC TESTING

NOTE: Determination of cardiac hypertrophy/dilatation is required; the suggested order of testing for cardiac hypertrophy/dilatation is EKG, then chest x-ray (PA and lateral), then echocardiogram. Echocardiogram is only necessary if the other two tests are negative. A limited echocardiogram, if available, is appropriate to determine if cardiac hypertrophy/dilatation is present by measuring only left ventricular dimension, wall thickness and ejection fraction.

5A. IS THERE EVIDENCE OF CARDIAC HYPERTROPHY OR DILATATION?
 YES NO

5B. DIAGNOSTIC TEST AND DATE GIVEN (Provide most recent test only)

- EKG - Date of EKG: _____
- CHEST X-RAY - Date of chest x-ray: _____
- ECHOCARDIOGRAM - Date of echocardiogram: _____
- OTHER STUDY (Specify): _____ (Date): _____

5C. LEFT VENTRICULAR EJECTION FRACTION (LVEF), IF KNOWN: _____ % DATE OF TEST: _____
 (If LVEF testing is not of record, but available medical information sufficiently reflects the severity of the veteran's cardiovascular condition, LVEF testing is not required)

SECTION VI - FUNCTIONAL IMPACT AND REMARKS

6. DOES THE VETERAN'S IHD IMPACT THE VETERAN'S ABILITY TO WORK?
 YES NO (If "Yes," describe impact, providing one or more examples)

SECTION VI - FUNCTIONAL IMPACT AND REMARKS (Continued)

7. REMARKS *(If any)*

SECTION VII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

8A. PHYSICIAN'S SIGNATURE		8B. PHYSICIAN'S PRINTED NAME	8C. DATE SIGNED
8D. PHYSICIAN'S PHONE AND FAX NUMBER	8E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	8F. PHYSICIAN'S ADDRESS	

NOTE: VA may obtain additional medical information, including an examination, 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.benefits.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 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 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.