OMB Approved No. 2900-0781
Respondent Burden: 15 Minutes
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Department of Veterans Affairs

FIBROMYALGIA 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 BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN *(First, Middle Initial, Last)*

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. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

SECTION I - DIAGNOSIS

NOTE - 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)*

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, 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 appropriate date determined through record review or reported history.

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

☐ FIBROMYALGIA ICD CODE: _____ DATE OF DIAGNOSIS: _____

☐ OTHER *(specify)*

OTHER DIAGNOSIS #1

_____ ICD CODE: _____ DATE OF DIAGNOSIS: _____

OTHER DIAGNOSIS #2

_____ ICD CODE: _____ DATE OF DIAGNOSIS: _____

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO FIBROMYALGIA, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL RECORD REVIEW

2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARATION OF THIS REPORT:

☐ C-FILE *(VA ONLY)*

☐ OTHER *(Describe):*

SECTION III - MEDICAL HISTORY

3A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S FIBROMYALGIA CONDITION:

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):*

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SECTION IV - FINDINGS, SIGNS, SYMPTOMS

4A. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO FIBROMYALGIA?

☐ YES ☐ 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

☐ MUSCLE WEAKNESS

☐ FATIGUE

☐ SLEEP DISTURBANCES

☐ PARESTHESIAS

☐ HEADACHE

☐ DEPRESSION

☐ ANXIETY

☐ IRRITABLE BOWEL SYMPTOMS

☐ RAYNAUD'S-LIKE SYMPTOMS

☐ OTHER *(describe):* _____

(For all checked conditions, describe) _____

***NOTE** - If Mental Health conditions, such as depression due to fibromyalgia are identified, a VA Form 21-0960P-2, Mental Disorders (Other than PTSD) Disability Benefits Questionnaire must ALSO be completed.*

4B. FREQUENCY OF FIBROMYALGIA SYMPTOMS *(check all that apply)*

☐ NO SYMPTOMS

☐ EPISODIC WITH EXACERBATIONS

☐ PRESENT MORE THAN ONE-THIRD OF THE TIME

☐ CONSTANT OR NEARLY CONSTANT

☐ OFTEN PRECIPITATED BY ENVIRONMENTAL OR EMOTIONAL STRESS OR OVEREXERTION *(If checked, describe):* _____

_____

☐ 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 *(If checked, indicate side):*	☐ Right	☐ Left	☐ Both
☐	Second rib: at second costochondral junction *(If checked, indicate side):*	☐ 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 *(If checked, indicate side):*	☐ Right	☐ Left	☐ Both
☐	Lateral epicondyle: 2 cm distal to lateral epicondyle *(If checked, indicate side):*	☐ Right	☐ Left	☐ Both
☐	Gluteal: at upper outer quadrant of buttocks *(If checked, indicate side):*	☐ Right	☐ Left	☐ Both
☐	Greater trochanter: posterior to greater trochanteric prominence *(If checked, indicate side):*	☐ Right	☐ Left	☐ Both
☐	Knee: medial joint line *(If checked, indicate side):*	☐ Right	☐ Left	☐ Both
☐	Other, specify: _____ *(If checked, indicate side):*	☐ Right	☐ Left	☐ Both

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

5. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY 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 condition, 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)):*

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SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S FIBROMYALGIA IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact of the veteran's fibromyalgia and provide 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/FAX NUMBERS	9E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	9F. PHYSICIAN'S ADDRESS

NOTE - VA may obtain 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.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, 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 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 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 **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.