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SECTION III - MEDICAL HISTORY

3A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S AUTOIMMUNE DISEASE, INCLUDING SLE (brief summary):

3B. OVER THE PAST 12 MONTHS, HAS THE VETERAN'S TREATMENT PLAN INCLUDED ORAL OR TOPICAL MEDICATIONS FOR ANY AUTOIMMUNE DISEASE OR AUTOIMMUNE DISORDER-RELATED SKIN CONDITION, INCLUDING SYSTEMIC, CUTANEOUS OR DISCOID LUPUS?

YES NO

(If "Yes," check all that apply)

Oral corticosteroids

(If checked, list medications and specify the condition medication is used for):

Total duration of medication use in past 12 months?

< 6 weeks 6 weeks or more, but not constant Constant/near-constant

Other immunosuppressive medications

(If checked, list medications and specify the condition medication is used for):

Total duration of medication use in past 12 months?

< 6 weeks 6 weeks or more, but not constant Constant/near-constant

Immunosuppressive retinoids

(If checked, list medications and specify the condition medication is used for):

Total duration of medication use in past 12 months?

< 6 weeks 6 weeks or more, but not constant Constant/near-constant

Topical corticosteroids

(If checked, list medications and specify the condition medication is used for):

Total duration of medication use in past 12 months?

< 6 weeks 6 weeks or more, but not constant Constant/near-constant

Other oral or topical medications used for an autoimmune condition

(If checked, list medications and specify the condition medication is used for):

Total duration of medication use in past 12 months?

< 6 weeks 6 weeks or more, but not constant Constant/near-constant

3C. INDICATE STATUS OF THE VETERAN'S AUTOIMMUNE DISEASE, INCLUDING SLE:

ACUTE CHRONIC OTHER (describe): _____

3D. DOES THE VETERAN HAVE EXACERBATIONS OF AN AUTOIMMUNE DISEASE, INCLUDING SLE?

YES NO (If "Yes," describe exacerbations (brief summary)):

Indicate average frequency of exacerbations per year:

0 1 2 3 More than 3 exacerbations per year

Indicate average duration of symptoms during each exacerbation:

Lasting less than one week

Lasting a week or more

Other (describe): _____

3E. DOES THE VETERAN'S AUTOIMMUNE DISEASE, INCLUDING SLE CURRENTLY PRODUCE SEVERE IMPAIRMENT OF HEALTH?

YES NO (If "Yes," describe the severe impairment of health):

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SECTION IV - CUTANEOUS MANIFESTATIONS

4. DOES THE VETERAN HAVE ANY CUTANEOUS MANIFESTATIONS OF AN AUTOIMMUNE DISEASE, INCLUDING SYSTEMIC, CUTANEOUS OR DISCOID LUPUS ERYTHEMATOSUS?

YES NO (If "Yes," complete the following Items 4A thru 4F)

A. Specify the cutaneous manifestations (check all that apply)

- Discoid lupus erythematosus
- Subacute cutaneous lupus erythematosus
- Other, describe: _____

B. Indicate areas affected by cutaneous manifestations (check all that apply)

- Malar rash over bridge of nose and bilateral cheeks, sparing nasolabial folds
- Cheeks (If checked, specify which side): Right Left Both
- Ears (If checked, specify which side): Right Left Both
- Nose
- Chin
- Lips and mouth, causing ulcers and scaling
- Hands
- Feet
- Scalp, causing scarring alopecia
- Other body areas, specify location: _____

Note: For all checked boxes in Item 4B, describe cutaneous manifestations:

C. Indicate approximate TOTAL body area affected by cutaneous manifestations of an autoimmune disease on current examination:

- None < 5% 5% to < 20% 20% to 40% > 40%

D. Indicate approximate total EXPOSED body area (face, neck and hands) affected by cutaneous manifestations of an autoimmune disease on current examination:

- None < 5% 5% to < 20% 20% to 40% > 40%

E. Do the cutaneous manifestations of the autoimmune disease cause scarring alopecia?

- Yes No (If "Yes," indicate percent of scalp affected):
- < 20% 20% to 40% > 40%

F. Do the cutaneous manifestations of the autoimmune disease cause scarring (including surgical scars related to the condition, if any) that is unstable, painful, causes disfigurement of the head, face or neck, or has a total area of all related scars greater than or equal to 39 square cm (6 square inches)?

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

SECTION V - FINDINGS, SIGNS AND SYMPTOMS

5. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS (other than cutaneous manifestations) ATTRIBUTABLE TO AN AUTOIMMUNE DISEASE, INCLUDING SLE?

Yes No (If "Yes," complete the following Items 5A thru 5K):

A. Has the veteran had any symptoms (other than cutaneous manifestations) attributable to an autoimmune disease, including SLE, in the past 2 years?

- Yes No

B. Does the veteran have arthritis attributable to an autoimmune disease, including SLE?

- Yes No (If "Yes," list affected joints and describe effect of autoimmune disease on each joint (brief summary) and ALSO complete the appropriate questionnaire for each affected joint):

C. Does the veteran have recurrent ulcers on oral mucous membranes attributable to an autoimmune disease, including SLE?

- Yes No

(If "Yes," do the recurrent ulcers result in impairment of mastication, a speech impairment or other signs or symptoms?)

- Yes No (If "Yes," describe):

D. Does the veteran have any hematologic or lymphatic manifestations of an autoimmune disease, including SLE?

- Yes No

(If "Yes," check all that apply)

- General adenopathy
- Splenomegaly
- Anemia
- Leukopenia (usually lymphopenia, with < 1500 cells/uL)
- Thrombocytopenia (sometimes life-threatening autoimmune thrombocytopenia)
- Other, describe: _____

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SECTION V - FINDINGS, SIGNS AND SYMPTOMS (Continued)

E. Does the veteran have any pulmonary manifestations of an autoimmune disease, including SLE?

Yes No

(If "Yes," check all that apply and ALSO complete VA Form 21-0960L-1, Respiratory Conditions Disability Benefits Questionnaire, including pulmonary function testing, if appropriate, on the questionnaire)

- Pulmonary emboli
- Pulmonary hypertension
- Shrinking lung syndrome
- Recurrent pleurisy, with or without pleural effusion
- Other, describe: _____

F. Does the veteran have any cardiac manifestations of an autoimmune disease, including SLE?

Yes No

(If "Yes," check all that apply and ALSO complete a VA Form 21-0960A-4, Heart Disease (including arrhythmias and surgery) Disability Benefits Questionnaire)

- Pericardial effusion
- Myocarditis
- Coronary artery vasculitis
- Valvular involvement
- Libman-Sacks endocarditis
- Other, describe: _____

G. Does the veteran have any neurologic manifestations of an autoimmune disease, including SLE?

Yes No

(If "Yes," describe and ALSO complete the appropriate neurologic questionnaire (i.e., VA Form 21-0960C-8, Headaches Disability Benefits Questionnaire, VA Form 21-0960C-5 Central Nervous System and Neuromuscular System Diseases Disability Benefits Questionnaire or VA Form 21-0960C-9, Multiple Sclerosis Disability Benefits Questionnaire)

H. Does the veteran have any renal manifestations of an autoimmune disease, including SLE?

Yes No

(If "Yes," check all that apply and ALSO complete the VA Form 21-0960J-1, Kidney Conditions Disability Benefits Questionnaire and/or VA Form 21-0960A-3, Hypertension Disability Benefits Questionnaire)

- Glomerular nephritis
- Membranoproliferative glomerulonephritis
- Proteinuria
- Hypertension
- Edema
- Other, describe: _____

I. Does the veteran have any obstetric manifestations of an autoimmune disease, including SLE?

Yes No *(If "Yes," describe):* _____

J. Does the veteran have any gastrointestinal manifestations of an autoimmune disease, including SLE?

Yes No

(If "Yes," describe and ALSO complete the appropriate GI questionnaire (i.e., VA Form 21-0960G-1, Esophageal Disorders Disability Benefits Questionnaire, VA Form 21-0960G-2, Gall Bladder and Pancreas Disability Benefits Questionnaire, VA Form 21-0960G-3, Intestines (other than surgical or infectious) Disability Benefits Questionnaire, VA Form 21-0960G-4, Intestines (surgical or infectious) Disability Benefits Questionnaire, VA Form 21-0960G-5, Hepatitis, Cirrhosis and other Liver Conditions Disability Benefits Questionnaire, VA Form 21-0960G-6, Peritoneal Adhesions Disability Benefits Questionnaire, and VA Form 21-0960G-7, Stomach and Duodenum Conditions Disability Benefits Questionnaire)

K. Does the veteran have any vascular (arterial or venous) manifestations of an autoimmune disease, including SLE?

Yes No

(If "Yes," check all that apply and ALSO complete the VA Form 21-0960A-2, Artery and Vein Conditions Disease Disability Benefits Questionnaire)

- Recurrent arterial thrombosis
- Recurrent venous thrombosis
- Other, describe: _____

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

6. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS?

YES NO (If "Yes," describe (brief summary)):

SECTION VII - DIAGNOSTIC TESTING

7. IF IMAGING STUDIES, DIAGNOSTIC PROCEDURES OR LABORATORY TESTING HAS BEEN PERFORMED AND REFLECTS THE VETERAN'S CURRENT CONDITION, PROVIDE MOST RECENT RESULTS AND NO FURTHER STUDIES OR TESTING ARE REQUIRED FOR THIS EXAMINATION (**NOTE: When appropriate provide most recent results**)

A. Have imaging studies been performed?

YES NO

(If "Yes," check all that apply):

- Chest x-ray Date: _____ Results: _____
- Magnetic resonance imaging (MRI) Date: _____ Results: _____
- Computed tomography (CT) Date: _____ Results: _____
- Other, describe: _____ Date: _____ Results: _____

B. Has laboratory testing been performed?

YES NO

(If "Yes," check all that apply):

- Hemoglobin (gm/100ml) Date: _____ Results: _____
- Hematocrit Date: _____ Results: _____
- Red blood cell (RBC) count Date: _____ Results: _____
- White blood cell (WBC) count Date: _____ Results: _____
- White blood cell differential count Date: _____ Results: _____
- Platelet count Date: _____ Results: _____
- Erythrocyte sedimentation rate (ESR) Date: _____ Results: _____
- C-reactive protein (CRP) Date: _____ Results: _____
- Antinuclear antibody (ANA) titer Date: _____ Results: _____
- Anti-Ro Antibody Date: _____ Results: _____
- Anti-Smith antibodies Date: _____ Results: _____
- Anti-Ro double strand (ds) DNA Date: _____ Results: _____
- Antiphospholipid Date: _____ Results: _____
- Complement components (C3 and C4) Date: _____ Results: _____
- BUN Date: _____ Results: _____
- Creatinine Date: _____ Results: _____
- Estimated glomerular filtration rate (EGFR) Date: _____ Results: _____
- Other, specify: _____ Date: _____ Results: _____

C. Has a urinalysis been performed?

YES NO

(If "Yes," complete the following):

Date of most recent urinalysis: _____

Results:

- Microalbumin: Not elevated Elevated to: _____
- Protein: None Trace 1+ 2+ 3+
- Glucose: None Trace 1+ 2+ 3+
- Hyaline casts: None 1-5 hyaline casts per LPF Other, describe: _____
- Granular casts: None 1-5 granular casts per LPF Other, describe: _____
- Blood: None Trace blood and no RBCs per HPF Trace blood and 1-5 RBCs per HPF 1+ blood and 1-5 RBCs per HPF 1+ blood and 5-10 RBCs per HPF 2+ blood and 10-20 RBCs per HPF Other, describe: _____

D. Are there any other significant diagnostic test findings and/or results?

YES NO (If "Yes," provide type of test or procedure, date and results (brief summary)):

SECTION VIII - FUNCTIONAL IMPACT

8. DOES THE VETERAN'S AUTOIMMUNE DISEASE IMPACT HIS OR HER ABILITY TO WORK?

YES NO (If "Yes," describe the impact of the veteran's autoimmune disease, providing one or more examples):

SECTION IX - REMARKS

9. REMARKS (If any)

SECTION X - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

10A. PHYSICIAN'S SIGNATURE	10B. PHYSICIAN'S PRINTED NAME	10C. DATE SIGNED
10D. PHYSICIAN'S PHONE/FAX NUMBERS	10E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	10F. 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.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 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.