

**SINUSITIS/RHINITIS AND OTHER CONDITIONS OF THE NOSE, THROAT,  
LARYNX AND PHARYNX  
DISABILITY BENEFITS QUESTIONNAIRE**

Name of Patient/Veteran \_\_\_\_\_ Patient/Veteran's Social Security Number \_\_\_\_\_ Date of examination: \_\_\_\_\_

**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.**

Note - The Veteran 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 may obtain additional medical information, including an examination, if necessary, to complete VA's review of the Veteran's application. VA reserves the right to confirm the authenticity of ALL completed questionnaires. **It is intended that this questionnaire will be completed by the Veteran's healthcare provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

Veteran/Claimant

Third party (please list name(s) of organization(s) or individual(s))

Other: please describe

Are you a VA Healthcare provider?     Yes     No

Is the Veteran regularly seen as a patient in your clinic?     Yes     No

Was the Veteran examined in person?     Yes     No

If no, how was the examination conducted?

**EVIDENCE REVIEW**

Evidence reviewed:

No records were reviewed

Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

**SECTION I - DIAGNOSIS**

Note: These are condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. List the claimed condition(s) that pertain to this questionnaire:

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(s), 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 approximate date determined through record review or reported history.

1B. Select diagnoses associated with the claimed condition(s) (check all that apply):

<input type="checkbox"/>	The Veteran does not have a current diagnosis associated with any claimed condition(s) listed above. (Explain your findings and reasons in the Remarks section)		
<input type="checkbox"/>	Chronic sinusitis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Allergic rhinitis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Non-allergic rhinitis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Bacterial rhinitis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Granulomatous rhinitis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Chronic laryngitis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Laryngectomy	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Laryngeal stenosis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Aphonia	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Pharyngeal injury (describe)	ICD code: _____	Date of diagnosis: _____
<hr/>			
<input type="checkbox"/>	Deviated nasal septum	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Anatomical loss of part of nose (Complete Scars Benefits Questionnaire in lieu of this questionnaire)	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Benign or malignant neoplasm of sinus, nose, throat, larynx or pharynx	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/>	Other (specify)		
	Other diagnosis #1 _____	ICD code _____	Date of diagnosis _____
	Other diagnosis #2 _____	ICD code _____	Date of diagnosis _____
	Other diagnosis #3 _____	ICD code _____	Date of diagnosis _____

1C. If there are additional diagnoses that pertain to the sinuses, nose, throat, larynx or pharynx condition(s), list using above format:

**SECTION II - MEDICAL HISTORY**

2A. Describe the history (including onset and course) of the Veteran's sinus, nose, throat, larynx, or pharynx condition:

**SECTION III - NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS**

3A. Does the Veteran have any of the following nose, throat, larynx or pharynx conditions?

- Yes     No    (If "No," proceed to Section IV) (If "Yes," check all that apply):
- Sinusitis (If checked, complete Part A below)
  - Rhinitis (If checked, complete Part B below)
  - Larynx or pharynx condition (If checked, complete Part C below)
  - Deviated nasal septum (traumatic) (If checked, complete Part D below)
  - Tumors or neoplasms (If checked, complete Part E below)
  - Other nose, throat, larynx or pharynx conditions, pertinent physical findings or scars due to nose, throat, larynx or pharynx conditions. (if checked, complete Part F below)

**Part A - SINUSITIS**

A1. Indicate the sinuses/type of sinusitis currently affected by the Veteran's chronic sinusitis (Check all that apply):

- None     Maxillary     Frontal     Ethmoid     Sphenoid     Pansinusitis

A2. Does the Veteran currently have any findings, signs or symptoms attributable to chronic sinusitis?

- Yes     No    (If "Yes," check all that apply)
- Chronic sinusitis detected only by imaging studies (See Diagnostic Testing Section)
  - Episodes of sinusitis
  - Near constant sinusitis (If checked, describe frequency): \_\_\_\_\_
  - Headaches
  - Pain of affected sinus
  - Tenderness of affected sinus
  - Purulent discharge
  - Crusting
  - Other (describe): \_\_\_\_\_

For all checked conditions, describe: \_\_\_\_\_

A3. Has the Veteran had non-incapacitating episodes of sinusitis characterized by headaches, pain and purulent discharge or crusting in the past 12 months?

- Yes     No    (If "Yes," provide the total number of non-incapacitating episodes over the past 12 months):
- 1     2     3     4     5     6     7 or more

A4. Has the Veteran had incapacitating episodes of sinusitis requiring prolonged (4 to 6 weeks) of antibiotics treatment in the past 12 months?

NOTE - For VA purposes, an incapacitating episode of sinusitis means one that requires bed rest and treatment prescribed by a physician.

- Yes     No    (If "Yes," provide the total number of incapacitating episodes of sinusitis requiring prolonged (4 to 6 weeks) of antibiotic treatment over the past 12 months):
- 1     2     3 or more

A5. Has the Veteran had sinus surgery?

- Yes     No    (If "Yes," specify type of surgery):
- Radical (open sinus surgery)     Endoscopic     Other: \_\_\_\_\_
- (Type of procedure, sinuses operated on and side(s)): \_\_\_\_\_
- (Date(s) of surgery (if repeated sinus surgery, provide all dates of surgery)): \_\_\_\_\_

A6. If Veteran has had radical sinus surgery, did chronic osteomyelitis follow the surgery?

- Yes     No    (If "Yes," complete Osteomyelitis Questionnaire)

A7. Has the Veteran had repeated sinus-related surgical procedures performed?

Yes  No

**PART B - RHINITIS**

B1. Is there greater than 50% obstruction of the nasal passage on both sides due to rhinitis?

Yes  No

B2. Is there complete obstruction on the left side due to rhinitis?

Yes  No

B3. Is there complete obstruction on the right side due to rhinitis?

Yes  No

B4. Is there permanent hypertrophy of the nasal turbinates?

Yes  No

B5. Are there nasal polyps?

Yes  No

B6. Does the Veteran have any of the following granulomatous conditions?

Yes  No (If "Yes," check all that apply)

Granulomatous rhinitis  Rhinoscleroma  Wegener's granulomatosis  Lethal midline granuloma

Other granulomatous infection (Describe): \_\_\_\_\_

**PART C - LARYNX AND PHARYNX CONDITIONS**

C1. Does the Veteran have chronic laryngitis?

Yes  No

(If "Yes," does the Veteran have any of the following symptoms due to chronic laryngitis?)

Yes  No (If "Yes," check all that apply)

Hoarseness (if checked, describe frequency): \_\_\_\_\_

Inflammation of vocal cords

Inflammation of mucous membrane

Thickening of vocal cords

Nodules of vocal cords

Submucous infiltration of vocal cords

Vocal cord polyps

Other (describe): \_\_\_\_\_

C2. Has the Veteran had a laryngectomy?

Yes  No (If "Yes," specify)

Total laryngectomy

Partial laryngectomy

(If checked, does the Veteran have any residuals of the partial laryngectomy?)

Yes  No

(If "Yes," describe): \_\_\_\_\_

C3. Does the Veteran have laryngeal stenosis, including residuals of laryngeal trauma (unilateral or bilateral)?

Yes  No (If "Yes," assess for upper airway obstruction with pulmonary function testing to include Flow-Volume Loop, and provide results in Diagnostic Testing Section)

C4. Does the Veteran have complete organic aphonia?

Yes  No (If "Yes," check all that apply)

- Constant inability to speak above a whisper
- Constant inability to communicate by speech
- Other (describe): \_\_\_\_\_

C5. Does the Veteran have incomplete organic aphonia?

Yes  No (If "Yes," check all that apply)

- Hoarseness (If checked, describe frequency): \_\_\_\_\_
- Inflammation of vocal cords
- Inflammation of mucous membrane
- Thickening of vocal cords
- Nodules of vocal cords
- Submucous infiltration of vocal cords
- Vocal cord polyps
- Other (describe): \_\_\_\_\_

C6. Has the Veteran had a permanent tracheostomy?

Yes  No (If "Yes," describe reason for tracheostomy and potential for decannulation):

C7. Has the Veteran had an injury to the pharynx?

Yes  No (If "Yes," check all findings, signs and symptoms that apply):

- Obstruction of the pharynx
- Obstruction of the nasopharynx
- Stricture of the pharynx
- Stricture of the nasopharynx
- Absence of the soft palate secondary to trauma
- Absence of the soft palate secondary to chemical burn
- Absence of the soft palate secondary to granulomatous disease
- Paralysis of the soft palate
- Swallowing difficulty
- Nasal regurgitation
- Speech impairment
- Other (describe): \_\_\_\_\_

C8. Does the Veteran have vocal cord paralysis or any other pharyngeal or laryngeal conditions?

Yes  No (If "Yes," describe):

**PART D - DEVIATED NASAL SEPTUM**

D1. Is there at least 50% obstruction of the nasal passage on both sides due to traumatic septal deviation?

Yes  No

D2. Is the Veteran's deviated septum traumatic?

Yes  No

D3. Is there complete obstruction on left side due to traumatic septal deviation?

Yes  No

D4. Is there complete obstruction on right side due to traumatic septal deviation?

Yes  No

**PART E - TUMORS AND NEOPLASMS**

E1. Does the Veteran currently have, or has had, a benign or malignant neoplasm or metastases related to any condition in the diagnosis section?

Yes  No If yes, complete the following section.

E2. Is the neoplasm:

Benign

Malignant (if malignant complete the following):

Active  In remission

Primary  Secondary (metastatic) (if secondary, indicate the primary site, if known): \_\_\_\_\_

E3. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?

Yes  No; watchful waiting

If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

Treatment completed

Surgery

If checked, describe: \_\_\_\_\_

Date(s) of surgery: \_\_\_\_\_

Radiation therapy

Date of most recent treatment: \_\_\_\_\_

Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

Antineoplastic chemotherapy

Date of most recent treatment: \_\_\_\_\_

Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

Other therapeutic procedure

If checked, describe procedure: \_\_\_\_\_

Date of most recent procedure: \_\_\_\_\_

Other therapeutic treatment

If checked, describe treatment: \_\_\_\_\_

Date of completion of treatment or anticipated date of completion: \_\_\_\_\_

E4. Does the Veteran currently have any residuals or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?

Yes  No

If yes, list residuals or complications (brief summary), and also complete the appropriate questionnaire:

E5. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the diagnosis section, describe using the above format:

**PART F - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS**

F1. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to the conditions listed in the diagnosis section above?

Yes  No If yes, describe (brief summary):

F2. Does the Veteran have loss of part of the nose or other scars of the nose exposing both nasal passages?

Yes  No

F3. Does the Veteran have loss of part of the nose or other scars causing loss of part of one ala?

Yes  No

F4. Does the Veteran have loss of part of the nose or other scars causing any other disfigurement?

Yes  No

F5. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the diagnosis section above?

Yes  No If yes, also complete the appropriate dermatological questionnaire.

F6. Comments, if any:

**SECTION IV - DIAGNOSTIC TESTING**

Note: If testing has been performed and reflects the Veteran's current condition, repeat testing is not required. Specific diagnostic testing is not required for many conditions, but if performed, record in this section.

4A. Have clinically relevant imaging studies of the sinuses or other areas been performed or reviewed in conjunction with this examination?

Yes  No (If "Yes," check all that apply)

<input type="checkbox"/> Magnetic resonance imaging (MRI)	Date: _____	Results: _____
<input type="checkbox"/> Computed tomography (CT)	Date: _____	Results: _____
<input type="checkbox"/> X-rays:	Date: _____	Results: _____
<input type="checkbox"/> Other: _____	Date: _____	Results: _____

4B. Has endoscopy been performed?

Yes  No (If "Yes," check all that apply):

<input type="checkbox"/> Nasal endoscopy	Date: _____	Results: _____
<input type="checkbox"/> Laryngeal endoscopy	Date: _____	Results: _____
<input type="checkbox"/> Bronchoscopy	Date: _____	Results: _____
<input type="checkbox"/> Other endoscopy _____	Date: _____	Results: _____

4C. Has the Veteran had a biopsy of the larynx or pharynx?

Yes  No (If "Yes," complete the following):

Site of biopsy: \_\_\_\_\_ Date: \_\_\_\_\_

Results:  Benign  Pre-malignant  Malignant

Describe results: \_\_\_\_\_

4D. Has the Veteran had pulmonary function testing to assess for upper airway obstruction due to laryngeal stenosis?

Yes  No (If "Yes," indicate results):

FEV-1 of 71 to 80% predicted

FEV-1 of 56 to 70% predicted

FEV-1 of 40 to 55% predicted

FEV-1 less than 40% predicted

Is the Flow-Volume Loop compatible with upper airway obstruction?

Yes  No

4E. 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 V - FUNCTIONAL IMPACT

Note: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

5A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?

Yes  No

If yes, describe the functional impact of each condition, providing one or more examples:

**SECTION VI - REMARKS**

6A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

**SECTION VII - EXAMINER'S CERTIFICATION AND SIGNATURE**

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

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

<p>7A. Examiners signature: </p>	<p>7B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):</p>
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<p>7C. Examiner's area of practice/specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):</p>	<p>7D. Date signed:</p>
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<p>7E. Examiner's phone/fax numbers:</p>	<p>7F. National Provider Identifier (NPI) number:</p>	<p>7G. Medical license number and state:</p>
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7H. Examiner's address: