



**HEART CONDITIONS (INCLUDING ISCHEMIC AND NON-ISCHEMIC HEART DISEASE, ARRHYTHMIAS, VALVULAR DISEASE AND CARDIAC SURGERY) DISABILITY BENEFITS QUESTIONNAIRE**

**NOTE:** For coronary artery disease, myocardial infarction, or hypertensive disease, complete VA Form 21-0960A-1, Ischemic Heart Disease 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. VA reserves the right to confirm the authenticity of ALL DBQ's completed by private health care providers.

**SECTION I - DIAGNOSIS**

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A HEART CONDITION?

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

1B. SELECT THE VETERAN'S HEART CONDITION(S) (Check all that apply):

- |   |                 |                          |
|---|-----------------|--------------------------|
| <input type="checkbox"/> Acute, subacute, or old myocardial infarction  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Atherosclerotic cardiovascular disease   | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Coronary artery disease  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Stable angina  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Unstable angina  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Coronary spasm, including Prinzmetal's angina  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Congestive heart failure   | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Supraventricular arrhythmia  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Ventricular arrhythmia   | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Heart block  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Valvular heart disease   | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Heart valve replacement  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Cardiomyopathy   | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Hypertensive heart disease   | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Heart transplant   | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Implanted cardiac pacemaker  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Implanted automatic implantable cardioverter defibrillator (AICD)  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Infectious heart conditions (including active valvular infection, rheumatic heart disease, endocarditis, pericarditis or syphilitic heart disease) | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Pericardial adhesions  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Other heart condition, specify below   |                 |                          |
| Diagnosis #1: _____   | ICD Code: _____ | Date of diagnosis: _____ |
| Diagnosis #2: _____   | ICD Code: _____ | Date of diagnosis: _____ |

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

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S HEART CONDITION(S) (brief summary):

2B. DO ANY OF THE VETERAN'S HEART CONDITIONS QUALIFY WITHIN THE GENERALLY ACCEPTED MEDICAL DEFINITION OF ISCHEMIC HEART DISEASE (IHD)?

YES  NO (If "Yes," list the conditions that qualify):

**SECTION II - MEDICAL HISTORY (Continued)**

2C. PROVIDE THE ETIOLOGY, IF KNOWN, OF EACH OF THE VETERAN'S HEART CONDITIONS, INCLUDING THE RELATIONSHIP/CAUSALITY TO OTHER HEART CONDITIONS, PARTICULARLY THE RELATIONSHIP/CAUSALITY TO THE VETERAN'S IHD CONDITIONS, IF ANY:

Heart condition #1 (provide etiology): \_\_\_\_\_

Heart condition #2 (provide etiology): \_\_\_\_\_

2D. IF THERE ARE ADDITIONAL HEART CONDITIONS, PROVIDE ETIOLOGY AND LIST USING THE ABOVE FORMAT:

2E. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S HEART CONDITION?

YES  NO

(If, "Yes," list medications required for the veteran's heart condition (include name of medication and heart condition it is used for, such as atenolol for myocardial infarction or atrial fibrillation):

**SECTION III - MYOCARDIAL INFARCTION (MI)**

3A. HAS THE VETERAN HAD A MYOCARDIAL INFARCTION (MI)?

YES  NO (If, "Yes," complete the following):

MI #1: Date and treatment facility: \_\_\_\_\_

MI #2: Date and treatment facility: \_\_\_\_\_

3B. IF THE VETERAN HAS HAD ADDITIONAL MIs, LIST USING ABOVE FORMAT:

**SECTION IV - CONGESTIVE HEART FAILURE (CHF)**

4A. HAS THE VETERAN HAD CONGESTIVE HEART FAILURE (CHF)?

YES  NO (If "Yes," complete Item 4B)

4B. DOES THE VETERAN HAVE CHRONIC CHF?

YES  NO

4C. HAS THE VETERAN HAD ANY EPISODES OF ACUTE CHF IN THE PAST YEAR?

YES  NO

(If, "Yes," specify the number of episodes of acute CHF the veteran has had in the past year):

0  1  More than 1 Provide date of most recent episode of acute CHF: \_\_\_\_\_

4D. WAS THE VETERAN ADMITTED FOR TREATMENT OF ACUTE CHF?

YES  NO (If, "Yes," indicate name of treatment facility): \_\_\_\_\_

**SECTION V - ARRHYTHMIA**

5A. HAS THE VETERAN HAD A CARDIAC ARRHYTHMIA?

YES  NO (If "Yes," complete Item 5B)

5B. SELECT TYPE OF ARRHYTHMIA (Check all that apply):

Atrial fibrillation

(If checked, indicate frequency):  Constant  Intermittent (paroxysmal)

(If "Intermittent," indicate number of episodes in the past 12 months):  0  1 - 4  More than 4

(Indicate how these episodes were documented.) (Check all that apply):

EKG  Holter  Other, specify: \_\_\_\_\_

Atrial flutter

(If checked, indicate frequency):  Constant  Intermittent (paroxysmal)

(If "Intermittent," indicate number of episodes in the past 12 months):  0  1 - 4  More than 4

(Indicate how these episodes were documented.) (Check all that apply):

EKG  Holter  Other, specify: \_\_\_\_\_

Supraventricular tachycardia

(If checked, indicate frequency):  Constant  Intermittent (paroxysmal)

(If "Intermittent," indicate number of episodes in the past 12 months):  0  1 - 4  More than 4

(Indicate how these episodes were documented.) (Check all that apply):

EKG  Holter  Other, specify: \_\_\_\_\_

**SECTION V - ARRHYTHMIA (Continued)**

5B. SELECT TYPE OF ARRHYTHMIA (Check all that apply) (Continued)

- Atrioventricular block  
 I degree  II degree  III degree

Ventricular arrhythmia (sustained)  
(Indicate date of hospital admission for initial evaluation and medical treatment in Section IX, Procedures)

Other cardiac arrhythmia, specify: \_\_\_\_\_

(If checked, indicate frequency):  Constant  Intermittent (paroxysmal)

(If "Intermittent," indicate number of episodes in the past 12 months):  0  1 - 4  More than 4

(Indicate how these episodes were documented.) (Check all that apply):

EKG  Holter  Other, specify: \_\_\_\_\_

**SECTION VI - HEART VALVE CONDITIONS**

6A. HAS THE VETERAN HAD A HEART VALVE CONDITION?

- YES  NO (If "Yes," complete Item 6B)

6B. SELECT HEART VALVES AFFECTED (Check all that apply):

- Mitral  Tricuspid  Aortic  Pulmonary

6C. DESCRIBE TYPE OF HEART VALVE CONDITION FOR EACH CHECKED VALVE:

**SECTION VII - INFECTIOUS HEART CONDITIONS**

7A. HAS THE VETERAN HAD ANY INFECTIOUS CARDIAC CONDITIONS, INCLUDING ACTIVE VALVULAR INFECTION (INCLUDING RHEUMATIC HEART DISEASE), ENDOCARDITIS, PERICARDITIS OR SYPHILITIC HEART DISEASE?

- YES  NO (If "Yes," complete Item 7B)

7B. HAS THE VETERAN UNDERGONE OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR ANY ACTIVE INFECTION?

- YES  NO

(If, "Yes," describe treatment and site of infection being treated):

7C. HAS TREATMENT FOR AN ACTIVE INFECTION BEEN COMPLETED?

- YES  NO

(If, "Yes," provide date completed): \_\_\_\_\_

7D. HAS THE VETERAN HAD A SYPHILITIC AORTIC ANEURYSM?

- YES  NO (If "Yes," ALSO complete VA Form 21-0960A-2, Artery and Vein Conditions Disability Benefits Questionnaire)

**SECTION VIII - PERICARDIAL ADHESIONS**

8A. HAS THE VETERAN HAD PERICARDIAL ADHESIONS?

- YES  NO (If "Yes," complete Item 8B)

8B. SELECT ETIOLOGY OF PERICARDIAL ADHESIONS:

- Pericarditis  Cardiac surgery/bypass  Other, describe: \_\_\_\_\_

**SECTION IX - PROCEDURES**

9A. HAS THE VETERAN HAD ANY NON-SURGICAL OR SURGICAL PROCEDURES FOR THE TREATMENT OF A HEART CONDITION?

- YES  NO (If "Yes," complete Item 9B)

9B. INDICATE THE NON-SURGICAL OR SURGICAL PROCEDURES THE VETERAN HAS HAD FOR THE TREATMENT OF HEART CONDITIONS (Check all that apply):

Percutaneous coronary intervention (PCI) (angioplasty)  
Indicate date of treatment or date of admission if admitted for treatment and name of treatment facility: \_\_\_\_\_

Coronary artery bypass surgery  
Indicate date of admission for treatment and name of treatment facility: \_\_\_\_\_

Heart valve replacement  
Specify valve(s) replaced and type of valve(s): \_\_\_\_\_  
Indicate date of admission for treatment and name of treatment facility: \_\_\_\_\_

Heart transplants  
Indicate date of admission for treatment and name of treatment facility: \_\_\_\_\_

Implanted cardiac pacemaker  
Indicate date of admission for treatment and name of treatment facility: \_\_\_\_\_

**SECTION IX - PROCEDURES (Continued)**

9B. INDICATE THE NON-SURGICAL OR SURGICAL PROCEDURES THE VETERAN HAS HAD FOR THE TREATMENT OF HEART CONDITIONS (Continued)  
(Check all that apply):

- Implanted automatic implantable cardioverter defibrillator (AICD)  
Indicate date of admission for treatment and name of treatment facility: \_\_\_\_\_
  
- Valve replacement  
If checked indicate valve(s) that have been replaced (check all that apply):  
 Mitral    Tricuspid    Aortic    Pulmonary  
Indicate date of admission for treatment and name of treatment facility for each checked valve:  
\_\_\_\_\_
  
- Ventricular aneurysmectomy  
Indicate date of admission for treatment and name of treatment facility: \_\_\_\_\_
  
- Other surgical and/or non-surgical procedures for the treatment of a heart condition, describe: \_\_\_\_\_  
Indicate date of admission for treatment and name of treatment facility: \_\_\_\_\_  
Indicate the condition that resulted in the need for this procedure/treatment: \_\_\_\_\_

**SECTION X - HOSPITALIZATIONS**

10. HAS THE VETERAN HAD ANY OTHER HOSPITALIZATIONS FOR THE TREATMENT OF HEART CONDITIONS (OTHER THAN FOR NON-SURGICAL AND SURGICAL PROCEDURES DESCRIBED ABOVE)?

- YES    NO (If "Yes," provide the following):  
Date of admission for treatment and name of treatment facility: \_\_\_\_\_  
Condition that resulted in the need for hospitalization: \_\_\_\_\_

**SECTION XI - PHYSICAL EXAM**

11. PHYSICAL EXAM:

- Heart rate: \_\_\_\_\_
  
- Rhythm:             Regular             Irregular
  
- Point of maximal impact:     Not palpable     4th intercostal space     5th intercostal space     Other, specify: \_\_\_\_\_
  
- Heart sounds:             Normal             Abnormal, specify: \_\_\_\_\_
  
- Jugular-venous distension:     Yes             No
  
- Auscultation of the lungs:     Clear             Bibasilar rales     Other, describe: \_\_\_\_\_
  
- Peripheral pulses:

  - Dorsalis pedis:             Normal             Diminished             Absent
  - Posterior tibial:             Normal             Diminished             Absent

  
- Peripheral edema:

  - Right lower extremity:     None     Trace     1+     2+     3+     4+
  - Left lower extremity:     None     Trace     1+     2+     3+     4+

  
- Blood pressure: \_\_\_\_\_

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

12A. 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 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)

12B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

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

**SECTION XIII - DIAGNOSTIC TESTING**

**NOTE:** For VA purposes, exams for all heart conditions require a determination of whether or not cardiac hypertrophy or dilatation is present. The suggested order of testing for cardiac hypertrophy/dilatation is EKG, then chest x-ray (PA and lateral), then echocardiogram. An echocardiogram to determine heart size is only necessary if the other two tests are negative. Also for VA purposes, 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.

13A. IS THERE EVIDENCE OF CARDIAC HYPERTROPHY?

YES  NO

(If "Yes," indicate how this condition was documented):

EKG  Chest x-ray  Echocardiogram Date of test: \_\_\_\_\_

13B. IS THERE EVIDENCE OF CARDIAC DILATATION?

YES  NO

(If "Yes," indicate how this condition was documented):

Chest x-ray  Echocardiogram Date of test: \_\_\_\_\_

13C. SELECT ALL TESTING COMPLETED AND PROVIDE MOST RECENT RESULTS WHICH REFLECT THE VETERAN'S CURRENT FUNCTIONAL STATUS

(Check all that apply):

EKG

Date of EKG: \_\_\_\_\_

Result of EKG:

Normal

Arrhythmia, describe: \_\_\_\_\_

Hypertrophy, describe: \_\_\_\_\_

Ischemic, describe: \_\_\_\_\_

Other, describe: \_\_\_\_\_

Chest x-ray

Date of CXR: \_\_\_\_\_

Result of CXR:

Normal

Abnormal, describe: \_\_\_\_\_

Echocardiogram

Date of echocardiogram: \_\_\_\_\_

Left ventricular ejection fraction (LVEF): \_\_\_\_\_ %

Wall motion:  Normal  Abnormal, describe: \_\_\_\_\_

Wall thickness:  Normal  Abnormal, describe: \_\_\_\_\_

Holter monitor

Date of holter monitor test: \_\_\_\_\_

Result:

Normal

Abnormal, describe: \_\_\_\_\_

MUGA

Date of MUGA: \_\_\_\_\_

Left ventricular ejection fraction (LVEF): \_\_\_\_\_ %

Result:

Normal

Abnormal, describe: \_\_\_\_\_

Coronary artery angiogram

Date of angiogram: \_\_\_\_\_

Result:

Normal

Abnormal, describe: \_\_\_\_\_

CT angiography

Date of CT angiography: \_\_\_\_\_

Result:

Normal

Abnormal, describe: \_\_\_\_\_

Other test, specify:

Date of test: \_\_\_\_\_

Result: \_\_\_\_\_

**SECTION XIV - METs TESTING**

**NOTE:** For VA purposes, all heart exams require METs testing (either exercise-based or interview-based) to determine the activity level at which symptoms such as dyspnea, fatigue, angina, dizziness, or syncope develop (except exams for supraventricular arrhythmias.)

If a laboratory determination of METs by exercise testing cannot be done for medical reasons (e.g. chronic CHF or multiple episodes of acute CHF within the past 12 months), or if exercise-based METs test was not completed because it is not required as part of the veteran's treatment plan, or if exercise stress test results do not reflect veteran's current cardiac function, perform an interview-based METs test based on the veteran's responses to a cardiac activity questionnaire and provide the results below.

14A. INDICATE ALL TESTING COMPLETED PROVIDING ONLY MOST RECENT RESULTS WHICH REFLECT THE VETERAN'S CURRENT FUNCTIONAL STATUS.  
(Check all that apply):

Exercise stress test      Date of most recent exercise stress test: \_\_\_\_\_  
Results: \_\_\_\_\_  
METs level the veteran performed, if provided: \_\_\_\_\_

Interview-based METs test      Date of interview-based METs test: \_\_\_\_\_  
Symptoms during activity:  
The METs level checked below reflects the lowest activity level at which the veteran reports any of the following symptoms (check all symptoms that the veteran reports at the indicated METs level of activity):  
 Dyspnea    Fatigue    Angina    Dizziness    Syncope  
 Other, describe: \_\_\_\_\_

Results:  
METs level on most recent interview-based METs test:

(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

(>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)

(>5-7 METs)      This METs level has been found to be consistent with activities such as walking 1 flight of stairs, golfing (without cart), mowing lawn (push mower), heavy yard work (digging)

(>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)

The veteran denies experiencing above symptoms with any level of physical activity

14B. IF THE VETERAN HAS HAD BOTH AN EXERCISE STRESS TEST AND INTERVIEW-BASED METs TEST, INDICATE WHICH RESULTS MOST ACCURATELY REFLECT THE VETERAN'S CURRENT CARDIAC FUNCTIONAL LEVEL:

Exercise stress test     Interview-based METs test     N/A

14C. IS THE METs LEVEL LIMITATION DUE SOLELY TO THE HEART CONDITIONS?

YES     NO

(If "No," estimate the percentage of the METs level limitation that is due solely to the heart condition(s)):

0%    10%    20%    30%    40%    50%    60%    70%    80%    90%

The limitation in METs level is due to multiple factors; it is not possible to accurately estimate this percentage.

14D. IN ADDITION TO THE HEART CONDITION(S), DOES THE VETERAN HAVE OTHER NON-CARDIAC MEDICAL CONDITIONS (such as musculoskeletal or pulmonary conditions) LIMITING THE METs LEVEL?

YES     NO

(If "Yes," identify each condition and describe how each non-cardiac medical condition limits the veteran's METs level):

Other medical condition #1: \_\_\_\_\_ Effect on METs level: \_\_\_\_\_  
Other medical condition #2: \_\_\_\_\_ Effect on METs level: \_\_\_\_\_

14E. IF THERE ARE ADDITIONAL MEDICAL CONDITIONS AFFECTING METs LEVEL, LIST USING ABOVE FORMAT:

**SECTION XV - FUNCTIONAL IMPACT**

15. DOES THE VETERAN'S HEART CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

YES  NO (If "Yes," describe impact of each of the veteran's heart conditions, providing one or more examples)

**SECTION XVI - REMARKS**

16. REMARKS (If any)

**SECTION XVII - PHYSICIAN'S CERTIFICATION AND SIGNATURE**

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

17A. PHYSICIAN'S SIGNATURE

17B. PHYSICIAN'S PRINTED NAME

17C. DATE SIGNED

17D. PHYSICIAN'S PHONE NUMBER

17E. PHYSICIAN'S MEDICAL LICENSE NUMBER

17F. 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](http://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 30 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](http://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.