OMB Control No. 2900-0778
Respondent Burden: 15 Minutes
Expiration Date: 09/30/2019

Department of Veterans Affairs

HEADACHES (INCLUDING MIGRAINE HEADACHES) 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 THIS 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

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

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

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed below. 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 approximate date is determined through record review or reported history.

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

☐ Migraine including migraine variants	ICD Code: _____	Date of Diagnosis: _____
☐ Tension	ICD Code: _____	Date of Diagnosis: _____
☐ Cluster	ICD Code: _____	Date of Diagnosis: _____
☐ Other *(specify type of headache):* _____	ICD Code: _____	Date of Diagnosis: _____
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 A HEADACHE CONDITION, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S HEADACHE CONDITIONS *(brief summary):*

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

☐ YES ☐ NO IF YES, DESCRIBE TREATMENT *(list only those medications used for the diagnosed condition):*

SECTION III - SYMPTOMS

3A. DOES THE VETERAN EXPERIENCE HEADACHE PAIN?

☐ YES ☐ NO

(If "Yes," check all that apply to headache pain):

☐ Constant head pain
☐ Pulsating or throbbing head pain
☐ Pain localized to one side of the head
☐ Pain on both sides of the head
☐ Pain worsens with physical activity
☐ Other, describe: _____

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION III - SYMPTOMS *(Continued)*

3B. DOES THE VETERAN EXPERIENCE NON-HEADACHE SYMPTOMS ASSOCIATED WITH HEADACHES? *(Including symptoms associated with an aura prior to headache pain)*

☐ YES ☐ NO

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

☐ Nausea
☐ Vomiting
☐ Sensitivity to light
☐ Sensitivity to sound
☐ Changes in vision *(such as scotoma, flashes of light, tunnel vision)*
☐ Sensory changes *(such as feeling of pins and needles in extremities)*
☐ Other, describe: _____

3C. INDICATE DURATION OF TYPICAL HEAD PAIN

☐ Less than 1 day
☐ 1-2 days
☐ More than 2 days
☐ Other, describe: _____

3D. INDICATE LOCATION OF TYPICAL HEAD PAIN

☐ Right side of head
☐ Left side of head
☐ Both sides of head
☐ Other, describe: _____

SECTION IV - PROSTRATING ATTACKS OF HEADACHE PAIN

4A. MIGRANE - DOES THE VETERAN HAVE CHARACTERISTIC PROSTRATING ATTACKS OF MIGRAINE HEADACHE PAIN?

☐ YES ☐ NO

(If "Yes," indicate frequency, on average, of prostrating attacks over the last several months):

☐ Less than once every 2 months
☐ Once in 2 months
☐ Once every month
☐ More frequently than once per month

4B. DOES THE VETERAN HAVE VERY FREQUENT PROSTRATING AND PROLONGED ATTACKS OF MIGRAINE HEADACHE PAIN?

☐ YES ☐ NO

4C. NON-MIGRAINE - DOES THE VETERAN HAVE PROSTRATING ATTACKS OF NON-MIGRAINE HEADACHE PAIN?

☐ YES ☐ NO

(If "Yes," indicate frequency, on average, of prostrating attacks over the last several months):

☐ Less than once every 2 months
☐ Once in 2 months
☐ Once every month
☐ More frequently than once per month

4D. DOES THE VETERAN HAVE VERY FREQUENT PROSTRATING AND PROLONGED ATTACKS OF NON-MIGRAINE HEADACHE PAIN?

☐ YES ☐ NO

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

5A. 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?

☐ YES ☐ NO

If Yes, are any of these scars painful or unstable; have a total area equal to or greater than 39 square cm (6 square inches); or are located on the head, face or neck?

☐ YES ☐ NO

(If "Yes," also complete VA Form 21-0960F-1 Scars/Disfigurement Disability Benefits Questionnaire.)
(If "No," provide location and measurements of scar in centimeters.

LOCATION: _____

MEASUREMENTS: Length _____ cm X width _____ cm

NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in the Remarks section below. It is not necessary to also complete a Scars DBQ.

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS *(Continued)*

5B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO

(If "Yes," describe in a brief summary):

SECTION VI - DIAGNOSTIC TESTING

NOTE: Diagnostic testing is not requested for this examination report; if studies have already been completed, provide the most recent results below.

6. 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 VII - FUNCTIONAL IMPACT

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

☐ YES ☐ NO *(If "Yes," describe impact of the veteran's headache condition, providing 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 AND FAX NUMBER	9E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	9F. 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, 58VA21/22/28, 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 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.