Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
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	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
RAMSEY, JUBAR	XXX-XX-1013

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.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA21-2507, C&P EXAMINATION REQUEST?

☒ YES ☐ NO

How was the examination completed (check all that apply)?

☒ In-person examination

☒ Records reviewed

☐ Examination via approved video telehealth

☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

EVIDENCE REVIEWED *(check all that apply)*:

☐ Not requested
☐ VA claims file (hard copy paper C-file)
☒ VA e-folder (VBMS or Virtual VA)
☐ CPRS
☐ Other (please identify other evidence reviewed):
☐ No records were reviewed

EVIDENCE COMMENTS:
P.1644; Medical records show Veteran served in the Marine Corps from 11/28/2011 until 05/30/2015
P. 223: Treatment notes by Brannon Sean dated 07/07/2023 noted, "I have a headache especially when I move my jaw" following MVA and reported hittig right side of the temple against door frame of car.

SECTION I - DIAGNOSIS

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

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

IF YES, SELECT THE VETERAN'S CONDITION *(check all that apply)*:

☒ Migraine including migraine variants	ICD Code: G43	Date of Diagnosis: 06/17/2024
☐ 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:

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)*:

When did this condition begin? Veteran 3 years ago.
Describe how the condition began (e.g. injury or illness)? Headaches. He states that another Veteran told him it could be linked to Tinnitus.
What were the symptoms when the condition began? Headaches
Have you been treated for this condition? If yes, specify past medication, surgery and other types of treatment and describe response to the treatment. No
What are your current symptoms? He reports headaches daily.
What is your current treatment? For medication, specify name and dosage. He states he takes Tylenol as needed.
Describe the impact of the condition on your ability to perform occupational functioning and ordinary activities. He states it affects his concentration

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)*:

He states he takes Tylenol as needed.

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:

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:

SECTION III – SYMPTOMS *(Continued)*

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

Note: For VA purposes, the term prostrating means "causing extreme exhaustion, powerlessness, debilitation or incapacitation with substantial inability to engage in ordinary activities." Please complete both questions 4A and 4B.

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

☒ YES ☐ NO

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

- ☐ With less frequent attacks
- ☐ Once in 2 months
- ☒ Once every month
- ☐ Greater than once per month

4B. DOES THE VETERAN HAVE COMPLETELY PROSTRATING AND PROLONGED ATTACKS OF MIGRAINES/NON-MIGRAINE PAIN?

☐ YES ☒ NO

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

- ☐ With less frequent attacks
- ☐ Once in 2 months
- ☐ Once every month
- ☐ Greater than once per month

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

5A. 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)*:

5B. 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, 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? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

☐ YES ☐ NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION: MEASUREMENTS: length cm X width cm

NOTE: If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

5C. COMMENTS, IF ANY:

SECTION VI - DIAGNOSTIC TESTING

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

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

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)*:

Veteran would have difficulty with concentrationq.

SECTION VIII - REMARKS

8. REMARKS *(If any)*

For the claimant's claimed condition of migraines (headaches) please refer to the diagnosis section.

The suicide risk level is not at elevated acute risk.

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
Stella Mbah DNP FNP-BC be3dff30-a499-41e5-826b-e2bab78e4769	MBAH STELLA DNP, NP-C NURSE PRACTITIONER	20240620 (UTC)

9D. PHYSICIAN'S PHONE AND FAX NUMBER	9E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	9F. PHYSICIAN'S ADDRESS
4109639577 4432005261	NPI#:1851787725 Lic#:R174343 MD	7131 LIBERTY RD STE 100 GWYNN OAK MD 21207