HEART
Section 1

Please address the history questions below for: coronary artery disease

When did this condition begin? 1992

Describe how the condition began (e.g. injury or illness)?

CHRONIC CHEST PAIN

What were the symptoms when the condition began?

CHRONIC CHEST PAIN

Have you been treated for this condition? If yes, specify past medication, surgery and other types of treatment and describe response to the treatment.

CABG X 6 11-1-92
2X STENTS 5-29-14
STENTS 5-23-15

What are your current symptoms?

OCCASIONAL CHEST PAIN

Describe the impact of the condition on your ability to perform occupational functioning and ordinary activities.

SEVERLY LIMITED EXERTION
EVENTUALLY IT WILL KILL ME

IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE CLAIMANT'S HEART CONDITION?

(•) YES ( ) NO

Heart Medication:	Condition/Diagnosis:

Please list additonal heart medications in the same format as above.

MALE REPRO
Section 1

Please address the history questions below for: prostate cancer

When did this condition begin? 2019

Describe how the condition began (e.g. injury or illness)?

HIGH PSA

What were the symptoms when the condition began?

NONE

Have you been treated for this condition? If yes, specify past medication, surgery and other types of treatment and describe response to the treatment.

NOT YET

What are your current symptoms?

NONE

Describe the impact of the condition on your ability to perform occupational functioning and ordinary activities.

NONE

EVENTUALY IT COULD KILL ME

DM

SECTION I

Please address the history questions below for: Diabetes mellitus type II

When did this condition begin? 2018

Describe how the condition began (e.g. injury or illness)?

HIGH GLUCOSE

What were the symptoms when the condition began?

NONO

Have you been treated for this condition? If yes, specify past medication, surgery and other types of treatment and describe response to the treatment.

DIET, METFORMIN

What are your current symptoms?

What is your current treatment? For medication, specify name and dosage.

METFORMIN 500mg X1 MORNING X1 NIGHTS

Describe the impact of the condition on your ability to perform occupational functioning and ordinary activities.

NONE SOFAR

1.TREATMENT (Check all that apply)

☐ NONE

☑ MANAGED BY RESTRICTED DIET

☑ PRESCRIBED ORAL HYPOGLYCEMIC AGENT(S)

☐ INSULIN REQUIRED ○ 1 INJECTION PER DAY ○ MORE THAN 1 INJECTION PER DAY

☐ OTHER (Describe)

2.REGULATION OF ACTIVITIES

DOES THE CLAIMANT REQUIRE REGULATION OF ACTIVITIES AS PART OF MEDICAL MANAGEMENT OF DIABETES MELLITUS?

○ Yes ◉ No

(If "Yes," provide one or more examples of how the veteran must regulate his or her activities):

Has your medical provider told you to avoid strenuous occupational and recreational activities with the intention of avoiding hypoglycemic episodes.

3.FREQUENCY OF DIABETIC CARE SIX MONTHS

HOW FREQUENTLY DOES THE CLAIMANT VISIT HIS OR HER DIABETIC CARE PROVIDER FOR EPISODES OF KETOACIDOSIS?

◉ LESS THAN 2 TIMES PER MONTH ○ 2 TIMES PER MONTH ○ WEEKLY

HOW FREQUENTLY DOES THE CLAIMANT VISIT HIS OR HER DIABETIC CARE PROVIDER FOR EPISODES OF HYPOGLYCEMIA?

◉ LESS THAN 2 TIMES PER MONTH ○ 2 TIMES PER MONTH ○ WEEKLY

4.HOSPITALIZATIONS FOR EPISODES OF KETOACIDOSIS OR HYPOGLYCEMIC REACTIONS N/A

HOW MANY EPISODES OF KETOACIDOSIS REQUIRED HOSPITALIZATION OVER THE PAST12 MONTHS? N/A

DM

0 ○ 1 ○ 2 ○ 3 OR MORE

HOW MANY EPISODES OF HYPOGLYCEMIA REQUIRED HOSPITALIZATION OVER THE PAST 12 MONTHS?

0 ○ 1 ○ 2 ○ 3 OR MORE