Veterans Affairs Canada | Anciens Combattants Canada

Protected information when completed.

Medical Questionnaire: Hypertension and Vascular Conditions

File No.:	Decision No.:
Service No(s).:	

Family name:	Given name:	Date of Birth:
Name of Physician:		Date of Examination:

MEDICAL DIAGNOSIS(ES) OF CLAIMED/PENSIONED CONDITION(S) REQUIRING EXAMINATION:

1. ______________________________

Is this diagnosis: ○ confirmed or ○ provisional?

Do you expect further medical improvement? ○ Yes ○ No
If yes, please comment and include approximate time frame:

2. ______________________________

Is this diagnosis: ○ confirmed or ○ provisional?

Do you expect further medical improvement? ○ Yes ○ No
If yes, please comment and include approximate time frame:

3. ______________________________

Is this diagnosis: ○ confirmed or ○ provisional?

Do you expect further medical improvement? ○ Yes ○ No
If yes, please comment and include approximate time frame:

Very specific information is required by Veterans Affairs Canada to evaluate and assess a client's claimed pensioned condition(s). As this information may not generally form part of the clinical history, please help us to collect this information by answering the following questions.

Please complete applicable sections only.

If additional recording space is required, please use the "additional comments" sheet.

MEDICAL HISTORY: Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors.

Injuries? ○ Yes ○ No **Describe (include dates)**

Are further diagnostic tests or consultations ongoing/planned? ○ Yes ○ No
If yes, indicate the nature of the test/consultation, and the appointment date (if known).

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PLEASE COMPLETE APPLICABLE SECTIONS ONLY

Hypertension:

History of blood pressure readings (please provide a minimum of 3 readings with dates):

Peripheral Vascular Arterial Disease:

Does the client experience intermittent claudication with walking? ◯ Yes ◯ No

Is walking distance limited as a result of claudication pain? ◯ Yes ◯ No

If yes, how far is the client able to walk? ◯ less than 25 meters ◯ 25 meters to 200 meters ◯ more than 200 meters

Is ulceration present secondary to peripheral vascular arterial disease? ◯ Yes ◯ No

If yes, indicate: ◯ right leg ◯ left leg ◯ both

Comments:

Varicose Veins:

Please describe varicose veins in terms of disfigurement, edema, skin changes and frequency of discomfort.

Is there evidence of healed ulceration? ◯ Yes ◯ No

If an active ulcer is present, comment on duration.

Deep Venous Thrombosis (DVT):

Does the client currently require thromboprophylaxis? ◯ Yes ◯ No

If yes, for how long? ◯ less than 1 year of treatment ◯ more than 1 year of treatment

Does the client have a post thrombotic leg syndrome? ◯ Yes ◯ No

If yes, please describe:

Has the client had a recurrent DVT while on thromboprophylaxis? ◯ Yes ◯ No

If yes, please comment:

Has the client had a pulmonary embolus while on thromboprophalaxis? ◯ Yes ◯ No

If yes, please comment:

Family name:	Given name:	File No.:

Aneurysm and Intra-vascular Conditions:

Has the client had an embolus that has been successfully treated with no sequela? ◯ Yes ◯ No

Does the client have an abdominal aortic aneurysm? ◯ Yes ◯ No
If yes , please specify: ◯ diameter less than 6 cm ◯ diameter equal to or greater than 6 cm ◯ inoperable

If applicable, comment on other aneurysms the client may have:

Comments:

Raynaud's Disease/Phenomenon:

Indicate the frequency of 'characteristic attacks'. For pension assessment purposes a 'characteristic attack' is described as: sequential color changes of the digits of one or more extremities lasting minutes to hours, sometimes with pain and paresthesia, and precipitated by exposure to cold or by emotional upset.

◯ less than 1 episode per week ◯ 1 - 3 episodes per week ◯ 4 - 6 episodes per week ◯ daily

If applicable, describe ulceration.

Comments:

Frostbite, Immersion Foot and Other Cold Injuries:

Describe hypersensitivity to cold exposure: ◯ mild ◯ moderate ◯ severe

If applicable, describe permanent skin changes:

Comments:

PLEASE ATTACH/FORWARD COPIES OF RELEVANT REPORTS (E.G. DIAGNOSTIC, CONSULTATION, OPERATIVE, LABORATORY, HOSPITAL DISCHARGE SUMMARIES)

TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response), details of relevant surgery/hospitalization and other therapies (e.g. physiotherapy).

Family name:	Given name:	File No.:

COMPLICATIONS:

Are there any complications resulting from the claimed/pensioned condition(s)? ◯ Yes ◯ No

If yes, please provide details:

PHYSICAL EXAMINATION: (fill out only portion applicable to the pensioned/claimed condition(s))

Height ________ Weight ________ Blood Pressure ________ Pulse ________ Respiration ________

GENERAL APPEARANCE:

EXAMINATION FINDINGS: Describe any relevant examination findings.

Hypertension (Using a Mercury Sphygmomanometer with appropriate cuff size)

Blood Pressure:

Sitting	Right Arm ________	Left Arm ________
Lying	Right Arm ________	Left Arm ________

Pulses:

	Right	Left
Femoral	◯ Normal ◯ Diminished ◯ Absent	◯ Normal ◯ Diminished ◯ Absent
Popliteal	◯ Normal ◯ Diminished ◯ Absent	◯ Normal ◯ Diminished ◯ Absent
Posterior Tibialis	◯ Normal ◯ Diminished ◯ Absent	◯ Normal ◯ Diminished ◯ Absent
Dorsalis Pedis	◯ Normal ◯ Diminished ◯ Absent	◯ Normal ◯ Diminished ◯ Absent

Other, please specify and indicate:	Right	Left
________	◯ Normal ◯ Diminished ◯ Absent	◯ Normal ◯ Diminished ◯ Absent

OTHER PERTINENT FINDINGS: (i.e. other conditions that may be contributing to the client's impairment)

Physician's signature:	Is VAC to be invoiced? ◯ Yes ◯ No	Telephone No. ( )	Today's date:

Family name:	Given name:	File No.:

Additional Comments:

Physician's signature:	Today's date: