



Veteran

UIN

Please assess the following conditions:

1. Please select the most appropriate description of any symptoms.

Description	Select One
Asymptomatic.	<input type="checkbox"/>
Alopecia (other than male pattern baldness).	<input type="checkbox"/>
Symptoms which are easily tolerated .	<input type="checkbox"/>
Symptoms that are not easily tolerated .	<input type="checkbox"/>
Persistent disorder resulting in continuous signs and significant symptoms of moderate degree .	<input type="checkbox"/>
Severe and persistent pruritus causing difficulty in concentrating and loss of sleep .	<input type="checkbox"/>

2. How many hours are the symptoms present each day?

3. How many weeks per year is the veteran symptomatic to this degree?

4. Please select the most accurate description of the involvement of the **face and hands**.

Description	Select One
None or minor.	<input type="checkbox"/>
Noticeable disorder on face or hands, of such degree as would cause embarrassment to most people in unfamiliar social context.	<input type="checkbox"/>
Disorders resulting in significant loss of structural integrity of face , e.g. total loss of pinna, skin graft, scar following trauma or burns.	<input type="checkbox"/>
Gross loss of structural integrity of face and extensive or extreme facial disfigurement .	<input type="checkbox"/>
Severe and persistent ulcerative, weeping or suppurative skin disorders involving the greater part of the both the face and the hands.	<input type="checkbox"/>

5. Please select the most accurate description of the involvement of other body regions **excluding the face and hands**.

Description	Select One
None or minor.	<input type="checkbox"/>
Visible condition of such degree as would cause embarrassment or considerable inconvenience to most people in domestic or intimate situations.	<input type="checkbox"/>
Visible condition of such degree as would cause them to curtail sporting or recreational activities .	<input type="checkbox"/>

6. Does the veteran require medication for the skin condition(s)? ☐ Yes ☐ No

7. With regard to the **removal of solar skin lesions** in the past year (surgery, cautery and cryotherapy).

a. How many **treatment episodes** occurred?

b. How many **individual lesions** have been removed?

8. Are there any other comments you would like to make regarding the veteran's skin condition(s)?

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9. Please list **all conditions** contributing to the reported impairment and indicate the **percentage contribution**. Include any previously known condition(s) and any new condition(s) you have identified. The contribution total must equal 100%.

Condition	Contribution %
e.g. Psoriasis	75%
Total	100%

Doctor's signature	Doctor's name	Date	Time to complete form
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