



Veteran

UIN

Please assess the following conditions:

1. Do any of these conditions require **anticoagulant medication**? ☐ Yes ☐ No
2. Are any of these conditions **difficult to control** (e.g. requiring prolonged, extensive, or non-standard treatment)? ☐ Yes ☐ No

3. Please select **all** that apply with regard to any **aneurysms**.

Description	Select
None.	<input type="checkbox"/>
Iliac or femoral or carotid aneurysm.	<input type="checkbox"/>
Cerebral aneurysm (corrected).	<input type="checkbox"/>
Cerebral aneurysm (not corrected).	<input type="checkbox"/>

4. Please select **all** that apply with regard to any **aortic aneurysms**.

Description	Select
None.	<input type="checkbox"/>
Aortic aneurysm of diameter less than 6cm .	<input type="checkbox"/>
Aortic aneurysm of diameter greater than 6cm .	<input type="checkbox"/>
Aortic aneurysm surgically corrected .	<input type="checkbox"/>

5. 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. Arrhythmia	75%
Total	100%

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