# Form D2: Clinician-assessed Medical Conditions

**INSTRUCTIONS:** This form is to be completed by a physician, physician’s assistant, nurse practitioner, or other qualified practitioner. For additional clarifications and examples, see UDS Coding Guidebook for Initial Visit Packet, Form D2.

## Medical conditions and procedures

The following questions should be answered based on review of all available information, including new diagnoses made during the current visit, previous medical records, procedures, laboratory tests, and the clinical exam.

1. Cancer (excluding non-melanoma skin cancer), primary or metastatic
   - 0 No **(SKIP TO QUESTION 2)**
   - 1 Yes, primary/non-metastatic
   - 2 Yes, metastatic
   - 8 Not assessed **(SKIP TO QUESTION 2)**
   1a. If yes, specify primary site: ________________________________

If any of the conditions below are present (even if successfully treated), please check Yes.

2. Diabetes
   - 0 No
   - 1 Yes, Type I
   - 2 Yes, Type II
   - 3 Yes, other type (diabetes insipidus, latent autoimmune diabetes/type 1.5, gestational diabetes)
   - 9 Not assessed or unknown

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<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Not assessed</th>
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### If any of the conditions below are present (even if successfully treated), please check Yes.

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<tr>
<th>No</th>
<th>Yes</th>
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11. **Arthritis**  *If No or Not assessed, SKIP TO QUESTION 12*

   11a. If yes, what type?
   - [ ] 1 Rheumatoid
   - [ ] 2 Osteoarthritis
   - [ ] 3 Other (SPECIFY): ________________________________
   - [ ] 9 Unknown

   11b. If yes, regions affected (check at least one):
   - [ ] 1 Upper extremity
   - [ ] 2 Lower extremity
   - [ ] 3 Spine
   - [ ] 4 Unknown

12. Incontinence — urinary

13. Incontinence — bowel

14. Sleep apnea

15. REM sleep behavior disorder (RBD)

16. Hyposomnia/insomnia

17. Other sleep disorder (SPECIFY): ________________________________

18. Carotid procedure: angioplasty, endarterectomy, or stent

19. Percutaneous coronary intervention: angioplasty and/or stent

20. Procedure: pacemaker and/or defibrillator

21. Procedure: heart valve replacement or repair

22. Antibody-mediated encephalopathy
   - 22a. Specify antibody: ________________________________

23. Other medical conditions or procedures not listed above
   (IF YES, SPECIFY): ________________________________

   - [ ] 0
   - [ ] 1
   - [ ] 8