Department of Veterans Affairs

MALE REPRODUCTIVE ORGAN CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY OR REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM.

Note - The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the veteran's application. VA reserves the right to confirm the authenticity of ALL Questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

☐ Veteran/Claimant

☐ Other, please describe:

Are you a VA Healthcare provider? ◯ Yes ◯ No

Is the Veteran regularly seen as a patient in your clinic? ◯ Yes ◯ No

Was the Veteran examined in person? ◯ Yes ◯ No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

◯ No records were reviewed

◯ Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE EVER BEEN DIAGNOSED WITH ANY CONDITIONS OF THE MALE REPRODUCTIVE SYSTEM?

☐ YES ☐ NO *If "Yes," complete Item 1B*

1B. INDICATE DIAGNOSES: *(check all that apply)*

☐ Erectile dysfunction ICD code: _____ Date of diagnosis: _____

☐ Penis, deformity *(e.g., Peyronie's)* ICD code: _____ Date of diagnosis: _____

☐ Testis, atrophy, one or both ICD code: _____ Date of diagnosis: _____

☐ Testis, removal, one or both ICD code: _____ Date of diagnosis: _____

☐ Epididymitis, chronic ICD code: _____ Date of diagnosis: _____

☐ Epididymo-orchitis, chronic ICD code: _____ Date of diagnosis: _____

☐ Prostate gland injuries, infections, hypertrophy, post-operative residuals

Specify specific diagnosis: _____

ICD code: _____ Date of diagnosis: _____

☐ Neoplasms of the male reproductive system ICD code: _____ Date of diagnosis: _____

☐ Other male reproductive system condition *(specify diagnosis, providing only diagnoses that pertain to the male reproductive system)*

Other diagnosis #1: _____ ICD code: _____ Date of diagnosis: _____

Other diagnosis #2: _____ ICD code: _____ Date of diagnosis: _____

1C. IF THERE ARE ANY ADDITIONAL DIAGNOSES THAT PERTAIN TO THE MALE REPRODUCTIVE ORGAN CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S MALE REPRODUCTIVE ORGAN CONDITION(S) *(brief summary):*

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITION?

☐ YES ☐ NO List medications taken for the male reproductive organ condition:

_____

2C. HAS THE VETERAN HAD AN ORCHIECTOMY?

☐ YES ☐ NO

Indicate testicle removed: ☐ Right ☐ Left ☐ Both

Indicate reason for removal:

☐ Undescended

☐ Congenitally underdeveloped

☐ Other, provide reason for removal:

_____

SECTION II - MEDICAL HISTORY *(Continued)*

2D. IS THERE ANY RENAL DYSFUNCTION DUE TO CONDITION?

☐ YES ☐ NO

(If the Veteran has impaired kidney function, also complete VA Form 21-0960J-1, Kidney Conditions (Nephrology) Disability Benefits Questionnaire

SECTION III - VOIDING DYSFUNCTION

DOES THE VETERAN HAVE A VOIDING DYSFUNCTION?

☐ YES ☐ NO *If yes, complete the following sections:*

3A. ETIOLOGY OF VOIDING DYSFUNCTION: _____

3B. DOES THE VOIDING DYSFUNCTION CAUSE URINE LEAKAGE?

☐ YES ☐ NO

Indicate severity *(check one):*

- ☐ Does not require the wearing of absorbent material
- ☐ Requires absorbent material which must be changed less than 2 times per day
- ☐ Requires absorbent material which must be changed 2 to 4 times per day
- ☐ Requires absorbent material which must be changed more than 4 times per day
- ☐ Other, describe: _____

3C. DOES THE VOIDING DYSFUNCTION REQUIRE THE USE OF AN APPLIANCE?

☐ YES ☐ NO

If yes, describe the appliance:

_____

3D. DOES THE VOIDING DYSFUNCTION CAUSE INCREASED URINARY FREQUENCY?

☐ YES ☐ NO

If yes, check all that apply:

- ☐ Daytime voiding interval between 2 and 3 hours
- ☐ Daytime voiding interval between 1 and 2 hours
- ☐ Daytime voiding interval less than 1 hour
- ☐ Nighttime awakening to void 2 times
- ☐ Nighttime awakening to void 3 to 4 times
- ☐ Nighttime awakening to void 5 or more times

3E. DOES THE VOIDING DYSFUNCTION CAUSE SIGNS OR SYMPTOMS OF OBSTRUCTED VOIDING?

☐ YES ☐ NO

If yes, check all that apply:

- ☐ Hesitancy
  - If checked, is hesitancy marked?
    - ☐ YES ☐ NO
- ☐ Slow stream
  - If checked, is stream markedly slow?
    - ☐ YES ☐ NO
- ☐ Weak stream
  - If checked, is stream markedly weak?
    - ☐ YES ☐ NO
- ☐ Decreased force of stream
  - If checked, is force of stream markedly decreased?
    - ☐ YES ☐ NO
- ☐ Obstructive symptomatology without stricture disease requiring dilatation one to two times per year
- ☐ Stricture disease requiring dilatation 1 to 2 times per year
- ☐ Stricture disease requiring periodic dilatation every 2 to 3 months
- ☐ Recurrent urinary tract infections secondary to obstruction
- ☐ Uroflowmetry peak flow rate less than 10 cc/sec
- ☐ Post void residuals greater than 150 cc
- ☐ Marked obstructive symptomatology
- ☐ Urinary retention requiring intermittent catheterization
- ☐ Urinary retention requiring continuous catheterization
- ☐ Other, describe: _____

SECTION IV - ERECTILE DYSFUNCTION

DOES THE VETERAN HAVE ERECTILE DYSFUNCTION?

☐ YES ☐ NO *If yes, complete the following section:*

4A. ETIOLOGY OF ERECTILE DYSFUNCTION*:* _____

4B. IF THE VETERAN HAS ERECTILE DYSFUNCTION, IS IT AS LIKELY AS NOT *(at least a 50% probability)* ATTRIBUTABLE TO ONE OF THE DIAGNOSES IN SECTION I, INCLUDING RESIDUALS OF TREATMENT FOR THIS DIAGNOSIS?

☐ YES ☐ NO

(If yes, specify the diagnosis to which the erectile dysfunction is as likely as not attributable): _____

4C. IF THE VETERAN HAS ERECTILE DYSFUNCTION, IS HE ABLE TO ACHIEVE AN ERECTION SUFFICIENT FOR PENETRATION AND EJACULATION WITHOUT MEDICATION?

☐ YES ☐ NO

If no, has the Veteran used medications for treatment of his erectile dysfunction?

☐ YES ☐ NO

If yes, is the Veteran able to achieve an erection sufficient for penetration and ejaculation with medication?

☐ YES ☐ NO

SECTION V - RETROGRADE EJACULATION

5A. DOES THE VETERAN HAVE RETROGRADE EJACULATION?

☐ YES ☐ NO *If yes, complete Item 5B and provide etiology of retrograde ejaculation*

If yes, provide etiology of retrograde ejaculation: _____

5B. IF THE VETERAN HAS RETROGRADE EJACULATION, IS IT AS LIKELY AS NOT *(at least a 50% probability)* ATTRIBUTABLE TO ONE OF THE DIAGNOSES IN SECTION I, INCLUDING RESIDUALS OF TREATMENT FOR THIS DIAGNOSIS?

☐ YES ☐ NO

If yes, specify the diagnosis to which the retrograde ejaculation is as likely as not attributable: _____

SECTION VI - MALE REPRODUCTIVE ORGAN INFECTIONS

6. DOES THE VETERAN HAVE A HISTORY OF CHRONIC EPIDIDYMITIS, EPIDIDYMO-ORCHITIS OR PROSTATITIS?

☐ YES ☐ NO

If yes, indicate all treatment modalities used for chronic epididymitis, epididymo-orchitis or prostatitis (check all that apply):

☐ No treatment

☐ Long-term drug therapy

If checked, list medications used and indicate dates for courses of treatment over the past 12 months:

_____

☐ Recurrent symptomatic infection requiring drainage/frequent hospitalization

If checked, indicate frequency of hospitalization:

☐ 1 or 2 per year

☐ > 2 per year

☐ Continuous intensive management

If checked, indicate types of treatment and medications used over past 12 months: _____

☐ Intermittent intensive management

If checked, indicate types of treatment and medications used over past 12 months: _____

☐ Other, describe: _____

SECTION VII - PHYSICAL EXAM

7A. PENIS

☐ Normal

☐ Not examined per veteran's request

☐ Not examined per veteran's request; Veteran reports normal anatomy with no penile deformity or abnormality

☐ Not examined; penis exam not relevant to condition

☐ Abnormal

If abnormal, indicate severity:

☐ Loss/removal of less than half

☐ Loss/removal of half or more of penis

☐ Loss/removal of glans penis

☐ Penis deformity *(such as Peyronie's disease)*

If checked, describe:

SECTION VII - PHYSICAL EXAM (*Continued)*

7B. TESTES

- ☐ Normal
- ☐ Not examined per veteran's request
- ☐ Not examined per veteran's request; Veteran reports normal anatomy with no testicular deformity or abnormality
- ☐ Not examined; testicular exam not relevant to condition
- ☐ Abnormal

If abnormal, check all that apply:

Right testicle

- ☐ Complete atrophy of
- ☐ Size 1/3 or less of normal
- ☐ Size 1/2 to 1/3 of normal
- ☐ Considerably harder than normal
- ☐ Considerably softer than normal
- ☐ Absent
- ☐ Other abnormality

Describe: _____

Left testicle

- ☐ Complete atrophy of
- ☐ Size 1/3 or less of normal
- ☐ Size 1/2 to 1/3 of normal
- ☐ Considerably harder than normal
- ☐ Considerably softer than normal
- ☐ Absent
- ☐ Other abnormality

Describe: _____

7C. EPIDIDYMIS

- ☐ Normal
- ☐ Not examined per veteran's request
- ☐ Not examined per veteran's request; veteran reports normal anatomy of epididymis with no deformity or abnormality
- ☐ Not examined; epididymis exam not relevant to condition
- ☐ Abnormal

If abnormal, check all that apply:

Right epididymis

- ☐ Tender to palpation
- ☐ Other, describe: _____

Left epididymis

- ☐ Tender to palpation
- ☐ Other, describe: _____

7D. PROSTATE

- ☐ Normal
- ☐ Not examined per veteran's request
- ☐ Not examined; prostate exam not relevant to condition
- ☐ Abnormal

If abnormal, describe:

_____

SECTION VIII - TUMORS AND NEOPLASMS

DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO *If yes, complete the following section:*

8A. IS THE NEOPLASM:

☐ BENIGN ☐ MALIGNANT

- ☐ Active
- ☐ In remission
- ☐ NA

SECTION VIII - TUMORS AND NEOPLASMS *(Continued)*

8B. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

☐ YES ☐ NO; WATCHFUL WAITING

If yes, indicate type of treatment the veteran is currently undergoing or has completed (check all that apply):

☐ Treatment completed; currently in watchful waiting status

☐ Surgery

If checked, describe: _____

Date(s) of surgery: _____

☐ Radiation therapy

Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

☐ Antineoplastic chemotherapy

Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

☐ Other therapeutic procedure

If checked, describe procedure: _____

Date of most recent procedure: _____

☐ Other therapeutic treatment

If checked, describe treatment: _____

Date of completion of treatment or anticipated date of completion: _____

8C. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (INCLUDING METASTASES) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT ABOVE?

☐ YES ☐ NO *If yes, list residual conditions and complications (brief summary):*

8D. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION, DESCRIBE USING THE ABOVE FORMAT:

SECTION IX - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

9A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSCIAL FINDINGS, COMPLICATIONS, CONDITIONS, SIOGNS PR SYMPTOMS RELATED TO ANY CONDITIONS OLISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

If yes, describe (brief summary): : _____

9B. DOES THE VETERAN HAVE ANY SCARS (SURGIVAL OR OTHERWISE) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO *If yes, are any of these scars painful or unstable*

If yes, are any of the scars painful and/or unstable, have a total area equal to or greater than 39 square cm (6 square inches), or are located on the head, face or neck? (An "unstable scar " is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

☐ YES ☐ NO

If yes, also complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire.

If no, provide location and measurement of scar in centimeters.

Location: _____ Measurements: length _____ cm X width : _____ cm

NOTE: If there are multiple scars, enter additional locations and measurements in comments section below. It is not necessary to also complete a Scars DBQ.

9C. COMMENTS, IF ANY:

SECTION X - DIAGNOSTIC TESTING

NOTE: If imaging studies, diagnostic procedures or laboratory testing has been performed and reflects the Veteran's current condition, provide most recent results; no further studies or testing are required for this examination. When appropriate, provide most recent results. No specific studies are required for this examination.

10A. HAS A TESTICULAR BIOPSY BEEN PERFORMED?

☐ YES ☐ NO

Date of biopsy: _____

Results:

☐ Spermatozoa present

☐ Other, describe:

10 B. HAVE ANY OTHER IMAGING STUDIES, DIAGNOSTIC PROCEDURES OR LABORATORY TESTING BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO *If yes, provide type of test or procedure, date and results (brief summary):*

SECTION XI - FUNCTIONAL IMPACT

11. DOES THE VETERAN'S MALE REPRODUCTIVE SYSTEM CONDITION(S), INCLUDING NEOPLASMS, IF ANY, IMPACT HIS ABILITY TO WORK?

☐ YES ☐ NO *(If yes, describe impact of each of the veteran's male reproductive system conditions, providing one or more examples):*

SECTION XII - REMARKS

12. REMARKS *(if any)*

SECTION XIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

13A. PHYSICIAN'S SIGNATURE	13B. PHYSICIAN'S PRINTED NAME	13C. DATE SIGNED

13D. PHYSICIAN'S PHONE AND FAX NUMBER	13E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	13F. PHYSICIAN'S ADDRESS