OMB Approved No. 2900-XXXX
Respondent Burden: 30 minutes

Department of Veterans Affairs

GYNECOLOGICAL CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

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. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING THIS FORM.

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

NOTE TO PHYSICIAN - Your patient 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.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS SHE EVER HAD A GYNECOLOGICAL CONDITION?

☐ YES ☐ NO *(If "Yes," complete Item 1C) (If "No," complete Item 1B)*

1B. PROVIDE RATIONALE / REASON *(e.g. veteran does not currently have any known gynecological condition(s))*

1C. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO GYNECOLOGICAL CONDITION(S)?

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1D. IF THERE ARE ADDITIONAL GYNECOLOGICAL DIAGNOSES, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY *(including cause, onset and course)* OF THE VETERAN'S CURRENT GYNECOLOGICAL CONDITION(S):

SECTION III - FINDINGS, SIGNS AND SYMPTOMS

3. DOES THE VETERAN CURRENTLY HAVE SIGNS AND/OR SYMPTOMS RELATED A GYNECOLOGICAL CONDITION, INCLUDING ANY DISEASES, INJURIES OR ADHESIONS OF THE FEMALE REPRODUCTIVE ORGANS?

☐ YES ☐ NO

(If yes, indicate current signs, symptoms and/or severity of pain, if any: (check all that apply))

- ☐ No pain
- ☐ Intermittent pain
- ☐ Constant pain
- ☐ Mild pain
- ☐ Moderate pain
- ☐ Severe pain
- ☐ Pelvic pressure
- ☐ Irregular menstruation
- ☐ Frequent or continuous menstrual disturbances
- ☐ Other signs and/or symptoms, describe: _____

SECTION IV - TREATMENT

4A. HAS THE VETERAN HAD TREATMENT FOR SYMPTOMS RELATED TO ANY DISEASES, INJURIES AND/OR ADHESIONS OF THE REPRODUCTIVE TRACT?

☐ YES ☐ NO

(If yes, specify organ(s) affected and treatment): _____

Date of Treatment: _____

4B. DOES THE VETERAN CURRENTLY REQUIRE TREATMENT OR MEDICATIONS FOR SYMPTOMS RELATED TO REPRODUCTIVE TRACT CONDITIONS?

☐ YES ☐ NO

(If yes, list current treatment/medications prescribed for symptoms related to reproductive tract conditions):

SECTION IV - FINDINGS, SIGNS AND SYMPTOMS *(Continues)*

4C. If yes, indicate effectiveness of treatment in controlling symptoms:

- ☐ Symptoms do not require continuous treatment
- ☐ Symptoms require continuous treatment
- ☐ Symptoms are not controlled by continuous treatment

SECTION V - CONDITIONS OF THE VULVA

5. HAS THE VETERAN HAS BEEN DIAGNOSED WITH ANY DISEASES, INJURIES OR OTHER CONDITIONS OF THE VULVA *(to include vulvovaginitis)*?

☐ YES ☐ NO

(If yes, describe):

SECTION VI - CONDITIONS OF THE VAGINA

6. HAS THE VETERAN HAVE BEEN DIAGNOSED WITH ANY DISEASES, INJURIES OR OTHER CONDITIONS OF THE VAGINA?

☐ YES ☐ NO

(If yes, describe):

SECTION VII - CONDITIONS OF THE CERVIX

7. HAS THE VETERAN HAVE BEEN DIAGNOSED WITH ANY DISEASES, INJURIES, ADHESIONS OR OTHER CONDITIONS OF THE CERVIX?

☐ YES ☐ NO

(If yes, describe):

SECTION VIII - CONDITIONS OF THE UTERUS

8A. HAS THE VETERAN HAVE BEEN DIAGNOSED WITH ANY DISEASES, INJURIES, ADHESIONS OR OTHER CONDITIONS OF THE UTERUS?

☐ YES ☐ NO

8B. HAS THE VETERAN HAD A HYSTERECTOMY?

☐ YES ☐ NO

(If yes, provide date(s) of surgery and facility(ies) where performed):

8C. DOES THE VETERAN HAVE UTERINE PROLAPSE?

☐ YES ☐ NO

(If yes, indicate severity):

- ☐ Incomplete
- ☐ Complete *(through vagina and introitus)*

If yes, does the condition currently cause symptoms?

☐ YES ☐ NO

(If yes, describe):

8D. DOES THE VETERAN HAVE UTERINE FIBROIDS, ENLARGEMENT OF THE UTERUS AND/OR DISPLACEMENT OF THE UTERUS?

☐ YES ☐ NO

If yes, does the condition currently cause symptoms?

☐ YES ☐ NO

(If yes, check all that apply):

- ☐ Adhesions
- ☐ Marked displacement
- ☐ Marked enlargement
- ☐ Uterine fibroids
- ☐ Irregular menstruation
- ☐ Frequent or continuous menstrual disturbances
- ☐ Other, describe: _____

SECTION VIII - CONDITIONS OF THE UTERUS *(Continues)*

8E. HAS THE VETERAN HAVE BEEN DIAGNOSED WITH ANY OTHER DISEASES, INJURIES, ADHESIONS OR OTHER CONDITIONS OF THE UTERUS?

☐ YES ☐ NO

(If yes, describe):

SECTION IX - CONDITIONS OF THE FALLOPIAN TUBES

9. HAS THE VETERAN HAVE BEEN DIAGNOSED WITH ANY DISEASES, INJURIES, ADHESIONS OR OTHER CONDITIONS OF THE FALLOPIAN TUBES *(to include pelvic inflammatory disease)?*

☐ YES ☐ NO

(If yes, describe):

SECTION X - CONDITIONS OF THE OVARIES

10A. HAS THE VETERAN HAVE BEEN DIAGNOSED WITH ANY DISEASES, INJURIES, ADHESIONS OR OTHER CONDITIONS OF THE OVARIES *(including oophorectomy)*?

☐ YES ☐ NO

10B. HAS THE VETERAN UNDERGONE NATURAL MENOPAUSE?

☐ YES ☐ NO

10C. HAS THE VETERAN UNDERGONE SURGICAL, CHEMICAL-INDUCED, RADIATION-INDUCED OR PREMATURE MENOPAUSE PRIOR TO AGE 40 DUE TO ANY OTHER CAUSE?

☐ YES ☐ NO

10D. HAS THE VETERAN UNDERGONE OOPHORECTOMY?

☐ YES ☐ NO

(If yes, check all that apply):

- ☐ Partial removal of 1 or both ovaries
- ☐ Complete removal of 1 ovary
- ☐ Complete removal of both ovaries

(If yes, provide date(s) of surgery and facility(ies) where performed): _____

10E. DOES THE VETERAN HAVE EVIDENCE OF ATROPHY OF 1 OR BOTH OVARIES?

☐ YES ☐ NO ☐ UNKNOWN

If yes, indicate severity:

- ☐ Partial atrophy of 1 or both ovaries
- ☐ Complete atrophy of 1 ovary
- ☐ Complete atrophy of both ovaries *(excluding natural menopause)*

10F. HAS THE VETERAN HAVE BEEN DIAGNOSED WITH ANY OTHER DISEASES, INJURIES, ADHESIONS AND/OR OTHER CONDITIONS OF THE OVARIES?

☐ YES ☐ NO

(If yes, describe):

SECTION XI - INCONTINENCE

11. DOES THE VETERAN HAVE URINARY INCONTINENCE/LEAKAGE?

☐ YES ☐ NO

If yes, is the urinary incontinence/leakage due to a gynecologic condition?

☐ YES ☐ NO

(If yes, check all that apply):

- ☐ Does not require/does not use absorbent material
- ☐ Stress incontinence
- ☐ Requires absorbent material that is changed less than 2 times per day
- ☐ Requires absorbent material that is changed 2 to 4 times per day
- ☐ Requires absorbent material that is changed more than 4 times per day
- ☐ Requiring the use of an appliance

If checked, describe appliance: _____

SECTION XII - FISTULAE

12A. DOES THE VETERAN HAVE A RECTOVAGINAL FISTULA?

☐ YES ☐ NO

If yes, does the Veteran have vaginal-fecal leakage?

☐ YES ☐ NO

If yes, indicate frequency *(check all that apply)*:

- ☐ Less than once a week
- ☐ 1-3 times per week
- ☐ 4 or more times per week
- ☐ Daily or more often
- ☐ Requires wearing of pad or absorbent material

12B. DOES THE VETERAN HAVE AN URETHROVAGINAL FISTULA?

☐ YES ☐ NO

If yes, does the Veteran have urine leakage?

☐ YES ☐ NO

(If yes, check all that apply):

- ☐ Does not require/does not use absorbent material
- ☐ Requires absorbent material that is changed less than 2 times per day
- ☐ Requires absorbent material that is changed 2 to 4 times per day
- ☐ Requires absorbent material that is changed more than 4 times per day
- ☐ Requires the use of an appliance

If checked, describe appliance: _____

SECTION XIII - ENDOMETRIOSIS

NOTE - A diagnosis of endometriosis must be substantiated by laparoscopy.

13. HAS THE VETERAN HAVE BEEN DIAGNOSED WITH ENDOMETRIOSIS?

☐ YES ☐ NO

If yes, does the Veteran currently have any findings, signs or symptoms due to endometriosis?

☐ YES ☐ NO

(If yes, check all that apply):

- ☐ Pelvic pain
- ☐ Heavy or irregular bleeding requiring continuous treatment for control
- ☐ Heavy or irregular bleeding not controlled by treatment
- ☐ Lesions involving bowel or bladder confirmed by laparoscopy
- ☐ Bowel or bladder symptoms from endometriosis
- ☐ Anemia caused by endometriosis
- ☐ Other, describe: _____

SECTION XIV - COMPLICATIONS AND RESIDUALS OF PREGNANCY OR OTHER GYNECOLOGIC PROCEDURES

14A. HAS THE VETERAN HAD ANY SURGICAL COMPLICATIONS OF PREGNANCY?

☐ YES ☐ NO

(If yes, check all that apply):

- ☐ Relaxation of perineum
- ☐ Rectocele
- ☐ Cystocele
- ☐ Other, describe: _____

14B. HAS THE VETERAN HAD ANY OTHER COMPLICATIONS RESULTING FROM OBSTETRICAL OR GYNECOLOGIC CONDITIONS OR PROCEDURES?

☐ YES ☐ NO

(If yes, describe):

NOTE - If obstetrical or gynecologic complications impact other body systems, also complete the additional appropriate Questionnaire(s)

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

15A. DOES THE VETERAN HAVE ANY OTHER PERTINENT FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

☐ YES ☐ NO *(If yes, describe (brief summary))*:

15B. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO *(If "Yes," also complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)*

SECTION XVI - NEOPLASM

16. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT GYNECOLOGIC NEOPLASM?

☐ YES ☐ NO *(If "Yes," also complete VA Form 21-0960O-1, Tumors and Neoplasms Disability Benefits Questionnaire)*

SECTION XVII - DIAGNOSTIC TESTING

NOTE - If laboratory test results are in the medical record and reflect the Veteran's current condition, repeat testing is not required.

17A. HAS THE VETERAN HAD LAPAROSCOPY?

☐ YES ☐ NO

If yes, provide date(s) and facility where performed, and results: _____

17B. HAS THE VETERAN BEEN DIAGNOSED WITH ANEMIA?

☐ YES ☐ NO

If yes, provide most recent test results: Hgb: _____ Date of test: _____

17C. HAS THE VETERAN HAD ANY OTHER DIAGNOSTIC TESTING AND IF SO, ARE THERE SIGNIFICANT FINDINGS AND/OR RESULTS?

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

SECTION XVIII - FUNCTIONAL IMPACT

18. BASED ON YOUR EXAMINATION AND/OR THE VETERAN'S HISTORY DOES THE VETERAN'S GYNECOLOGICAL CONDITION(S) IMPACT HER ABILITY TO WORK?

☐ YES ☐ NO

If yes, describe impact of each of the Veteran's gynecological condition, providing one or more examples:

SECTION XIX - REMARKS

19. REMARKS *(If any)*

SECTION XX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

20A. PHYSICIAN'S SIGNATURE	20B. PHYSICIAN'S PRINTED NAME	20C. DATE SIGNED

20D. PHYSICIAN'S PHONE NUMBER	20E. PHYSICIAN'S MEDICAL LICENSE NUMBER	20F. PHYSICIAN'S ADDRESS

NOTE - VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the Veteran's application.

IMPORTANT - Physician please fax the completed form to _____

(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at www.vba.va.gov/disabilityexams or obtained by calling 1-800-827-1000.

Privacy Act Notice: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect proior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

Respondent Burden: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.