



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
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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 1B)

1B. 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 -

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

SECTION II - MEDICAL HISTORY

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

SECTION III - SYMPTOMS

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

YES NO

(If yes, indicate current symptoms including frequency and severity of pain, if any: (check all that apply))

- 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 and indicate condition(s) causing them: _____

SECTION IV - TREATMENT

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

YES NO

(If yes, specify condition(s), 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 and the reproductive organ conditions being treated): _____

SECTION IV - SYMPTOMS (Continues)

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

- Symptoms do not require continuous treatment for the following organ/condition: _____
- Symptoms require continuous treatment for the following organ/condition: _____
- Symptoms are not controlled by continuous treatment for the following organ/condition: _____

SECTION V - CONDITIONS OF THE VULVA

5. HAS THE VETERAN 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 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 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 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, facility(ies) where performed and cause):

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, are there signs and symptoms?

- YES NO

(If yes, check all that apply):

- Adhesions
- Marked displacement: If checked, indicate cause: _____
- Marked enlargement: If checked, indicate cause: _____
- Uterine fibroids
- Irregular menstruation: If checked, indicate cause: _____
- Frequent or continuous menstrual disturbances: If checked, indicate cause: _____
- Other, describe and indicate cause: _____

SECTION VIII - CONDITIONS OF THE UTERUS (Continues)

8E. HAS THE VETERAN 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 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 UNDERGONE MENOPAUSE?

YES NO (If yes, indicate):

- Natural menopause
- Premature menopause
- Surgical menopause
- Chemical-induced menopause
- Radiation-induced menopause

10B. HAS THE VETERAN UNDERGONE PARTIAL OR COMPLETE OOPHORECTOMY?

YES NO (If yes, check all that apply):

- Partial removal of an ovary
 - Right Left Both
- Complete removal of an ovary
 - Right Left Both

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

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

YES NO UNKNOWN (If yes, etiology): _____

(If yes, indicate severity):

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

10D. HAS THE VETERAN 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, condition causing it): _____

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, cause): _____

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, cause): _____

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 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 - TUMORS AND NEOPLASMS

15A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I?

YES NO (If "Yes," also complete Items 15B through 15E)

15B. IS THE NEOPLASM:

Benign Malignant

15C. 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: _____

15D. 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)):

15E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DESCRIBE USING THE ABOVE FORMAT:

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

16A. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I ABOVE?

YES NO

(If "Yes," are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches?))

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

16B. DOES THE VETERAN HAVE ANY OTHER PERTINENT FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I ABOVE?

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

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), facility where performed, and results: _____

17B. HAS THE VETERAN BEEN DIAGNOSED WITH ANEMIA?

YES NO

If yes, provide most recent test results: Hgb: _____ Hct: _____ 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. 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 AND FAX 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 prior 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.