OMB Approved No. 2900-0779
Respondent Burden: 15 Minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

PROSTATE CANCER 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 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. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE EVER BEEN DIAGNOSED WITH PROSTATE CANCER?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO PROSTATE CANCER

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 DIAGNOSES THAT PERTAIN TO PROSTATE CANCER, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (INCLUDING ONSET AND COURSE) OF THE VETERAN'S PROSTATE CANCER CONDITION *(Brief summary)*

2B. INDICATE STATUS OF THE DISEASE

☐ ACTIVE ☐ REMISSION

SECTION III - TREATMENT

3. HAS THE VETERAN COMPLETED ANY TREATMENT FOR PROSTATE CANCER OR IS THE VETERAN CURRENTLY UNDERGOING ANY TREATMENT FOR PROSTATE CANCER?

☐ YES ☐ NO, WATCHFUL WAITING *(If "Yes," specify treatment type(s)) (Check all that apply)*

- ☐ TREATMENT COMPLETED, CURRENTLY IN WATCHFUL WAITING STATUS
- ☐ SURGERY
  - ☐ PROSTATECTOMY
    - ☐ RADICAL PROSTATECTOMY
    - ☐ TRANSURETHRAL RESECTION PROSTATECTOMY
    - ☐ OTHER *(DESCRIBE):* _____
  - ☐ OTHER SURGICAL PROCEDURE *(DESCRIBE):* _____ *(DATE OF SURGERY):* _____
- ☐ RADIATION THERAPY *(DATE OF COMPLETION OF TREATMENT OR ANTICIPATED DATE OF COMPLETION):* _____
- ☐ BRACHYTHERAPY *(DATE OF TREATMENT):* _____
- ☐ ANTINEOPLASTIC CHEMOTHERAPY *(DATE OF COMPLETION OF TREATMENT OR ANTICIPATED DATE OF COMPLETION)*: _____
- ☐ ANDROGEN DEPRIVATION THERAPY *(HORMONAL THERAPY) (DATE OF COMPLETION OF TREATMENT OR ANTICIPATED DATE OF COMPLETION)*: _____
- ☐ OTHER THERAPEUTIC PROCEDURE AND/OR TREATMENT *(DESCRIBE):* _____

  (DATE OF PROCEDURE): _____

  (DATE OF COMPLETION OF TREATMENT OR ANTICIPATED DATE OF COMPLETION): _____

SECTION IV - VOIDING DYSFUNCTION

4. DOES THE VETERAN HAVE A VOIDING DYSFUNCTION?

☐ YES ☐ NO *(If "Yes," provide etiology of voiding dysfunction)* _____

(If the veteran has a voiding dysfunction, complete Items 4A through 4D)

A. 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)* _____

B. DOES THE VOIDING DYSFUNCTION REQUIRE THE USE OF AN APPLIANCE?

☐ YES ☐ NO *(If "Yes," describe the appliance)* _____

C. DOES THE VOIDING DYSFUNCTION CAUSE INCREASED URINARY FREQUENCY?

☐ YES ☐ NO

INDICATE FREQUENCY *(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

D. DOES THE VOIDING DYSFUNCTION CAUSE SIGNS OR SYSTEMS OF OBSTRUCTED VOIDING?

☐ YES ☐ NO *(If "Yes," check all that apply)*

- ☐ HESITANCY *(If checked, is hesitancy marked?)*
  - ☐ YES ☐ NO
- ☐ SLOW OR WEAK STREAM *(If checked, is stream markedly slow or weak?)*
  - ☐ YES ☐ NO
- ☐ DECREASED FORCE OF STREAM *(If checked, is force of stream markedly decreased?)*
  - ☐ YES ☐ NO
- ☐ 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
- ☐ URINARY RETENTION REQUIRING INTERMITTENT CATHETERIZATION
- ☐ URINARY RETENTION REQUIRING CONTINUOUS CATHETERIZATION
- ☐ OTHER *(Describe)*

SECTION V - URINARY TRACT/KIDNEY INFECTION

5. DOES THE VETERAN HAVE A HISTORY OF RECURRENT SYMPTOMATIC URINARY TRACT OR KIDNEY INFECTIONS?

☐ YES ☐ NO *(If "Yes," provide etiology)* _____

IF THE VETERAN HAS HAD RECURRENT SYMPTOMATIC URINARY TRACT OR KIDNEY INFECTIONS, INDICATE ALL TREATMENT MODALITIES 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)*
- ☐ HOSPITALIZATION *(If checked, indicate frequency of hospitalization)*
  - ☐ 1 OR 2 PER YEAR
  - ☐ > 2 PER YEAR
- ☐ DRAINAGE *(If checked, indicate dates when drainage performed over past 12 months)*
- ☐ 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 VI - ERECTILE DYSFUNCTION

6A. DOES THE VETERAN HAVE ERECTILE DYSFUNCTION?

☐ YES ☐ NO *(If "Yes," provide etiology)* _____

6B. 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)* _____

6C. IF THE VETERAN HAS ERECTILE DYSFUNCTION, IS HE ABLE TO ACHIEVE AN ERECTION SUFFICIENT FOR PENETRATION AND EJACULATION (WITHOUT MEDICATION)?

☐ YES ☐ NO *(If "No," is the veteran able to achieve an erection sufficient for penetration and ejaculation (with medication)?* ☐ YES ☐ NO

SECTION VII - RETROGRADE EJACULATION

7A. DOES THE VETERAN HAVE RETROGRADE EJACULATION?

☐ YES ☐ NO *(If "Yes," provide etiology of the retrograde ejaculation)* _____

7B. 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 VIII - RESIDUAL CONDITIONS AND/OR COMPLICATIONS

8. DOES THE VETERAN HAVE ANY OTHER RESIDUAL CONDITIONS AND/OR COMPLICATIONS DUE TO PROSTATE CANCER OR TREATMENT FOR PROSTATE CANCER?

☐ YES ☐ NO *(If "Yes," describe):*

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

9A. DOES THE VETERAN HAVE ANY SCARS (SURGICAL OR OTHERWISE) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO

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

☐ YES ☐ NO

(If "Yes," also complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)

9B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS?

☐ YES ☐ NO *(If "Yes," describe (brief summary))*

SECTION X - DIAGNOSTIC TESTING

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

10. ARE THERE ANY SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

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

SECTION XI - FUNCTIONAL IMPACT

11. DOES THE VETERAN'S PROSTATE CANCER IMPACT HIS ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of the veteran's prostate cancer, 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. PHYSICIAN'S MEDICAL LICENSE NUMBER	13F. 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.benefits.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 voluntary. 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 15 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.