OMB Approved No. 2900-0778
Respondent Burden: 30 Minutes
Expiration Date: XX/XX/XXXX

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. 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 SHE EVER HAD A GYNECOLOGICAL CONDITION?

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

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed below. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in the Remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date is determined through record review or reported history.

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(s) 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 *(Continued)*

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 *(Continued)*

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 "No,", complete 10C.)

(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, DIAGNOSIS?

☐ 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 ITEM 15C?

☐ 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 FORMAT IN ITEM 15C:

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 THE DIAGNOSIS SECTION?

☐ YES ☐ NO

(If "Yes," are any of the scars painful 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?)

☐ YES ☐ NO

(If "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire.)
(If "No,' provide location and measurements of scar in centimeters.)

Location: _____

Measurements: Length _____ cm X width _____ cm.

NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in the Remarks section below. It is not necessary to also complete a Scars DBQ.

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

☐ 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? *(If due to a gynecological condition noted in Section I.)*

☐ 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 conditions, 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 NUMBERS	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.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.