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

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## **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 GYNECO	DLOGICAL 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 DIAGNOSI	ES, LIST USING ABOVE FORMAT:			
	SECTION II - MEDICAL HISTORY			
2. DESCRIBE THE HISTORY (including cause, onset and course	e) OF EACH OF THE VETERAN'S GYNECOLOG	SICAL CONDITION(S):		
	SECTION III - SYMPTOMS			
3. DOES THE VETERAN CURRENTLY HAVE SYMPTOMS RELA OF THE FEMALE REPRODUCTIVE ORGANS?	ATED TO A GYNECOLOGICAL CONDITION, INC	CLUDING ANY DISEASES, INJURIES OR ADHESIONS		
YES NO				
(If yes, indicate current symptoms including frequency and seve	erity 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	on(s) causing them:			
44 HAS THE VETERAN HAD TREATMENT FOR SYMPTOMS/F	SECTION IV - TREATMENT	ADDITIONS OF THE DEDDODLICTIVE ODCANSS		
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 VIII CONDITIONS OF THE CERVIY
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):
(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?
L YES L NO
(If yes, provide date(s) of surgery, facility(ies) where performed and cause):
00 DOEC THE VETERAN HAVE LITERINE PROLADOFO
8C. DOES THE VETERAN HAVE UTERINE PROLAPSE?
YES NO
(If yes, indicate severity):  Incomplete
$L \sqsubseteq L = L L$
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 displacement: If checked, indicate cause:  Marked enlargement: If checked, indicate cause:
Marked enlargement: If checked, indicate cause:
Uterine fibroids  Irregular manetrustion: If checked, indicate cause:
Irregular menstruation: If checked, indicate cause:  Fraguent or continuous menstrual disturbances: If checked, indicate cause:
Frequent or continuous menstrual disturbances: If checked, indicate cause:  Other, describe and indicate cause:
Curier, 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):			
AFATION V. COMPITIONS OF THE OVARIES			
SECTION X - CONDITIONS OF THE OVARIES  10A. HAS THE VETERAN UNDERGONE MENOPAUSE?			
YES NO (If yes, indicate):			
TEO (1) yes, marcure).			
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):			
(gyes, province and (e) of an gary) furnity (res) with a part of a 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
<b>NOTE -</b> 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:
OFFICIAL VIIV. COMPLICATIONS AND PROPERTY OF PROPERTY OF COMPLETE COMPLICATION COMPLETE COMPLICATION COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE C
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
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	SECTION XVII - DIAGNOSTIC TESTING				
<b>NOTE</b> - If laboratory test results are in the medi	cal record and reflect the veteran's current cond	ition, 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 tes					
Hgb: Hct: Date of te  17C. HAS THE VETERAN HAD ANY OTHER DIAGNOS		FINDINGS AND/OD DESUITES			
	procedure, date and results (brief summary)):	FINDINGS AND/OR RESULTS!			
SECTION XVIII - FUNCTIONAL IMPACT					
18. DOES THE VETERAN'S GYNECOLOGICAL COND  YES NO (If ves, describe impact of eac.)	ITION(S) IMPACT HER ABILITY TO WORK?  In of the veteran's gynecological conditions, providing				
	, , , , , , , , , , , , , , , , , , ,				
	SECTION XIX - REMARKS				
19. REMARKS (If any)					
SECTI	ON XX - PHYSICIAN'S CERTIFICATION AND S	IGNATURE			
<b>CERTIFICATION</b> - To the best of my knowled	dge, the information contained herein is accurate	e, 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.)					
<b>NOTE -</b> A list of VA Regional Office FAX Numbers can be found at <a href="www.benefits.va.gov/disabilityexams">www.benefits.va.gov/disabilityexams</a> 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 <a href="https://www.reginfo.gov/public/do/PRAMain">www.reginfo.gov/public/do/PRAMain</a>. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.