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

Department of Veterans Affairs

MALE REPRODUCTIVE ORGAN 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 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 ANY CONDITIONS OF THE MALE REPRODUCTIVE SYSTEM?

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

1B. INDICATE DIAGNOSES: *(check all that apply)*

☐ Erectile dysfunction	ICD code: _____	Date of diagnosis: _____
☐ Penis, deformity *(e.g., Peyronie's)*	ICD code: _____	Date of diagnosis: _____
☐ Testis, atrophy, one or both	ICD code: _____	Date of diagnosis: _____
☐ Testis, removal, one or both	ICD code: _____	Date of diagnosis: _____
☐ Epididymitis, chronic	ICD code: _____	Date of diagnosis: _____
☐ Epididymo-orchitis, chronic	ICD code: _____	Date of diagnosis: _____
☐ Prostate injury	ICD code: _____	Date of diagnosis: _____
☐ Prostate hypertrophy *(BPH)*	ICD code: _____	Date of diagnosis: _____
☐ Prostatitis, chronic	ICD code: _____	Date of diagnosis: _____
☐ Prostate surgical residuals *(as addressed in items 3–6)*	ICD code: _____	Date of diagnosis: _____
☐ Neoplasms of the male reproductive system	ICD code: _____	Date of diagnosis: _____
☐ Other male reproductive system condition *(specify diagnosis, providing only diagnoses that pertain to the male reproductive system)*		
Other diagnosis #1: _____	ICD code: _____	Date of diagnosis: _____
Other diagnosis #2: _____	ICD code: _____	Date of diagnosis: _____

1C. IF THERE ARE ANY ADDITIONAL DIAGNOSES THAT PERTAIN TO THE MALE REPRODUCTIVE ORGAN CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S MALE REPRODUCTIVE ORGAN CONDITION(S) *(brief summary):*

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING CONTINUOUS MEDICATION FOR THE DIAGNOSED CONDITION?

☐ YES ☐ NO List medications taken for the male reproductive organ condition: _____

2C. HAS THE VETERAN HAD AN ORCHIECTOMY?

☐ YES ☐ NO

Indicate testicle removed: ☐ Right ☐ Left ☐ Both

Indicate reason for removal:

☐ Undescended
☐ Congenitally underdeveloped
☐ Other, provide reason for removal: _____

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION III - VOIDING DYSFUNCTION

3A. DOES THE VETERAN HAVE A VOIDING DYSFUNCTION?

☐ YES ☐ NO *(If yes, complete Items 3B thru 3E)*

(If yes, provide etiology of voiding dysfunction): _____

3B. 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: _____

3C. DOES THE VOIDING DYSFUNCTION REQUIRE THE USE OF AN APPLIANCE?

☐ YES ☐ NO

(If yes, describe the appliance): _____

3D. DOES THE VOIDING DYSFUNCTION CAUSE INCREASED URINARY FREQUENCY?

☐ YES ☐ NO

(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

3E. DOES THE VOIDING DYSFUNCTION CAUSE SIGNS OR SYMPTOMS 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 IV - URINARY TRACT/KIDNEY INFECTION

4A. DOES THE VETERAN HAVE A HISTORY OF RECURRENT SYMPTOMATIC URINARY TRACT OR KIDNEY INFECTIONS?

☐ YES ☐ NO *(If yes, complete Item 4B)*

(If yes, provide etiology of recurrent urinary tract or kidney infections): _____

4B. INDICATE ALL TREATMENT MODALITIES USED FOR RECURRENT URINARY TRACT OR KIDNEY INFECTIONS *(check all 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:

_____

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV - URINARY TRACT/KIDNEY INFECTION *(Continued)*

4B. INDICATE ALL TREATMENT MODALITIES USED FOR RECURRENT URINARY TRACT OR KIDNEY INFECTIONS *(check all that apply) (Continued):*

☐ 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 V - ERECTILE DYSFUNCTION

5A. DOES THE VETERAN HAVE ERECTILE DYSFUNCTION?

☐ YES ☐ NO *(If yes, complete Items 5B and 5C)*

(If yes, provide etiology of erectile dysfunction): _____

5B. 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): _____

5C. 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 VI - RETROGRADE EJACULATION

6A. DOES THE VETERAN HAVE RETROGRADE EJACULATION?

☐ YES ☐ NO *(If yes, complete Item 6B and provide etiology of retrograde ejaculation)*

(If yes, provide etiology of retrograde ejaculation): _____

6B. 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 erectile dysfunction is as likely as not attributable): _____

SECTION VII - MALE REPRODUCTIVE ORGAN INFECTIONS

7. DOES THE VETERAN HAVE A HISTORY OF CHRONIC EPIDIDYMITIS, EPIDIDYMO-ORCHITIS OR PROSTATITIS?

☐ YES ☐ NO

(If yes, indicate all treatment modalities used for chronic epididymitis, epididymo-orchitis or prostatitis (check all 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

☐ 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:

_____

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SECTION VIII - PHYSICAL EXAM

8A. PENIS

- ☐ Normal
- ☐ Not examined per veteran's request
- ☐ Not examined per veteran's request; Veteran reports normal anatomy with no penile deformity or abnormality
- ☐ Not examined; penis exam not relevant to condition
- ☐ Abnormal

If abnormal, indicate severity:

- ☐ Loss/removal of half or more of penis
- ☐ Loss/removal of glans penis
- ☐ Penis deformity *(such as Peyronie's disease)*

If checked, describe: _____

8B. TESTES

- ☐ Normal
- ☐ Not examined per veteran's request
- ☐ Not examined per veteran's request; Veteran reports normal anatomy with no testicular deformity or abnormality
- ☐ Not examined; testicular exam not relevant to condition
- ☐ Abnormal

If abnormal, check all that apply:

Right testicle

- ☐ Size 1/3 or less of normal
- ☐ Size 1/2 to 1/3 of normal
- ☐ Considerably harder than normal
- ☐ Considerably softer than normal
- ☐ Absent
- ☐ Other abnormality

Describe: _____

Left testicle

- ☐ Size 1/3 or less of normal
- ☐ Size 1/2 to 1/3 of normal
- ☐ Considerably harder than normal
- ☐ Considerably softer than normal
- ☐ Absent
- ☐ Other abnormality

Describe: _____

8C. EPIDIDYMIS

- ☐ Normal
- ☐ Not examined per veteran's request
- ☐ Not examined per veteran's request; veteran reports normal anatomy of epididymis with no deformity or abnormality
- ☐ Not examined; epididymis exam not relevant to condition
- ☐ Abnormal

If abnormal, check all that apply:

Right epididymis

- ☐ Tender to palpation
- ☐ Other, describe: _____

Left epididymis

- ☐ Tender to palpation
- ☐ Other, describe: _____

8D. PROSTATE

- ☐ Normal
- ☐ Not examined per veteran's request
- ☐ Not examined; prostate exam not relevant to condition
- ☐ Abnormal

If abnormal, describe:

_____

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IX - TUMORS AND NEOPLASMS

9A. 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, complete Items 9B thru 9E)*

9B. IS THE NEOPLASM:

☐ BENIGN ☐ MALIGNANT

9C. 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: _____

9D. 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)):*

9E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS, DESCRIBE USING THE ABOVE FORMAT:

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

10A. DOES THE VETERAN HAVE ANY SCARS (SURGICAL OR OTHERWISE) RELATED TO ANY CONDITION 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.)

10B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS?

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

SECTION XI - DIAGNOSTIC TESTING

NOTE: If imaging studies, diagnostic procedures or laboratory testing has been performed and reflects the veteran's current condition, provide most recent results; no further studies or testing are required for this examination. When appropriate, provide most recent results. No specific studies are required for this examination.

11A. HAS A TESTICULAR BIOPSY BEEN PERFORMED?

☐ YES ☐ NO

Date of biopsy: _____

Results:

☐ Spermatozoa present

☐ Other, describe:

_____

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SECTION XI - DIAGNOSTIC TESTING *(Continued)*

11B. HAVE ANY OTHER IMAGING STUDIES, DIAGNOSTIC PROCEDURES OR LABORATORY TESTING BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

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

SECTION XII - FUNCTIONAL IMPACT

12. DOES THE VETERAN'S MALE REPRODUCTIVE SYSTEM CONDITION(S), INCLUDING NEOPLASMS, IF ANY, IMPACT HIS ABILITY TO WORK?

☐ YES ☐ NO *(If yes, describe impact of each of the veteran's male reproductive system conditions, providing one or more examples):*

SECTION XI - REMARKS

13. REMARKS *(if any)*

SECTION XII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

14A. PHYSICIAN'S SIGNATURE	14B. PHYSICIAN'S PRINTED NAME	14C. DATE SIGNED

14D. PHYSICIAN'S PHONE AND FAX NUMBER	14E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	14F. 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.