Department of Veterans Affairs

MALE REPRODUCTIVE ORGAN CONDITIONS (INCLUDING PROSTATE CANCER) DISABILITY BENEFITS QUESTIONNAIRE

Name of Patient/Veteran	Patient/Veteran's Social Security Number	Date of examination:

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.

Note - The Veteran 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 may obtain additional medical information, including an examination, if necessary, to complete VA's review of the Veteran's application. VA reserves the right to confirm the authenticity of ALL completed questionnaires. **It is intended that this questionnaire will be completed by the Veteran's healthcare provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

☐ Veteran/Claimant

☐ Third party (please list name(s) of organization(s) or individual(s))

☐ Other: please describe

Are you a VA Healthcare provider? ◯ Yes ◯ No

Is the Veteran regularly seen as a patient in your clinic? ◯ Yes ◯ No

Was the Veteran examined in person? ◯ Yes ◯ No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

◯ No records were reviewed

◯ Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

SECTION I - DIAGNOSIS

Note: These are condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

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 1C

Note: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. 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 determined through record review or reported history.

1B. Select diagnoses associated with the claimed condition(s). Check all that apply.

☐ Erectile dysfunction, with or without penile deformity	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: _____

☐ Orchitis (unilateral or bilateral), chronic only ICD code: _____ Date of diagnosis: _____

☐ Urethritis ICD code: _____ Date of diagnosis: _____

☐ Varicocele/Hydrocele ICD code: _____ Date of diagnosis: _____

☐ Prostatitis ICD code: _____ Date of diagnosis: _____

☐ Prostate gland injuries, infections, hypertrophy, postoperative residuals, bladder outlet obstruction ICD code: _____ Date of diagnosis: _____

Specify specific diagnosis: _____

☐ Neoplasms of the male reproductive system, including prostate cancer 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 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), including prostate cancer. 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:

For VA purposes, renal dysfunction includes evidence demonstrating the following for at least 3 consecutive months during the past 12 months: glomerular filtration rate (GFR) of less than 60 mL/min/1.73m2; or GFR from 60 to 89 mL/min/1.73m2 and the presence of at least one of the following: recurrent red blood cell (RBC) casts, white blood cell (WBC) casts, granular casts, structural kidney abnormalities (cystic, obstructive, or glomerular), or increased secretion of protein in the urine (proteinuria). GFR, estimated GFR (eGFR), and creatinine based approximations of GFR will be accepted for evaluation purposes when determined to be appropriate and calculated by a medical professional. Note: If the medical record contains multiple lab tests during this 12 month period, separated by at least 3 months, and there is no evidence to contradict those findings in the interim period, VA will accept that the demonstrated renal dysfunction has persisted for at least 3 consecutive months during the past 12 months.

2D.Is there any renal dysfunction due to any conditions listed in the diagnosis section?

◯ Yes ◯ No

If the Veteran has renal dysfunction, also complete the appropriate genitourinary questionnaire.

SECTION III - VOIDING DYSFUNCTION

3A. Does the Veteran have a voiding dysfunction?

◯ Yes ◯ No If yes, complete the remainder of section III.

3B. Etiology of voiding dysfunction: _____

3C. Does the voiding dysfunction cause urine leakage?

◯ Yes ◯ No

If yes, 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: _____

3D. Does the voiding dysfunction require the use of an appliance?

◯ Yes ◯ No

If yes, describe the appliance:

3E. 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

3F. Does the voiding dysfunction cause signs or symptoms of obstructed voiding?

◯ Yes ◯ No

If yes, check all that apply.

- ☐ Hesitancy
- ☐ Slow stream
- ☐ Weak stream
- ☐ Decreased force of stream
- ☐ Obstructive symptomatology without stricture disease requiring dilatation 1 to 2 times per year
- ☐ 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 - ERECTILE DYSFUNCTION

4A. Does the Veteran have erectile dysfunction?

◯ Yes ◯ No

If yes, provide etiology, if known.

☐ Etiology unknown

SECTION V - RETROGRADE EJACULATION

5A. Does the Veteran have retrograde ejaculation?

◯ Yes ◯ No

If yes, provide etiology, if known.

☐ Etiology unknown

SECTION VI - MALE REPRODUCTIVE ORGAN INFECTIONS, INCLUDING URINARY TRACT INFECTIONS

6A. Does the Veteran have a history of chronic prostatitis, urethritis, epididymitis, orchitis, or urinary tract infections?

◯ Yes ◯ No

If yes, indicate all treatment modalities used for chronic prostatitis, urethritis, epididymitis, orchitis, or urinary infections. Check all that apply.

☐ No treatment

☐ Recurrent symptomatic infection requiring drainage by stent or nephrostomy tube

If checked, indicate dates drainage was performed over the past 12 months: _____

☐ Recurrent symptomatic infection requiring hospitalization

If checked, indicate frequency of hospitalizations: ☐ 1 or 2 per year ☐ Greater than 2 times per year

☐ Recurrent symptomatic infection requiring continuous intensive management

If checked, indicate types of treatment and medications used over the past 12 months: _____

☐ Recurrent symptomatic infection requiring suppressive drug therapy

☐ For less than 6 months ☐ Lasting 6 months or longer

If checked, list medications used and indicate dates for courses of treatment over the past 12 months:

☐ Other, describe: _____

SECTION VII - PHYSICAL EXAM

7A. 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 checked, indicate the abnormality(ies)

☐ Loss/removal of less than half

☐ Loss/removal of half or more

☐ Loss/removal of glans

☐ Penis deformity

If checked, describe.

7B. Testes

☐ Normal Indicate side ☐ Right ☐ Left ☐ Both

☐ 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

☐ Complete atrophy of

☐ Size 1/3 or less of normal

☐ Size 1/2 or less, but more than 1/3 of normal

☐ Considerably harder than the contralateral (corresponding) normal testicle

☐ Considerably softer than the contralateral (corresponding) normal testicle

☐ Absent

☐ Other abnormality

Describe:

Left testicle

☐ Complete atrophy of

☐ Size 1/3 or less of normal

☐ Size 1/2 or less, but more than 1/3 of normal

☐ Considerably harder than the contralateral (corresponding) normal testicle

☐ Considerably softer than the contralateral (corresponding) normal testicle

☐ Absent

☐ Other abnormality

Describe:

7C. Epididymis

☐ Normal Indicate side ☐ Right ☐ Left ☐ Both

☐ 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

7D. Prostate

☐ Normal

☐ Not examined per Veteran's request

☐ Not examined; not medically advisable for reasons including, but not limited to, recent prostate surgery, recent seed implants, anal stricture/fissures/anal pain/anal surgery, thrombosed hemorrhoids, acute inflammation/prostatitis, and/or other reasons.

Please provide brief description:

☐ Not examined; prostate exam not relevant to condition

☐ Abnormal

If abnormal, describe.

SECTION VIII - TUMORS AND NEOPLASMS

8A. Does the Veteran currently have, or has had, a benign or malignant neoplasm or metastases related to any condition in the diagnosis section?

◯ Yes ◯ No

If yes, complete the remainder of section VIII.

8B. Is the neoplasm

☐ Benign

☐ Malignant (If malignant complete the following):

☐ Active ☐ In remission

☐ Primary ☐ Secondary (metastatic) If secondary, indicate the primary site, if known. _____

8C. 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

☐ Surgery

If checked, describe: _____

Date(s) of surgery: _____

☐ Prostatectomy

☐ Radical prostatectomy Date of surgery: _____

☐ Other, describe: _____ Date of surgery: _____

☐ Transurethral resection of the prostate (TURP) Date of surgery: _____

☐ Radiation therapy Date of completion of treatment or anticipated date of completion: _____

☐ Antineoplastic chemotherapy Date of completion of treatment or anticipated date of completion: _____

☐ Brachytherapy 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, if applicable: _____

Date of completion of treatment or anticipated date of completion, if applicable: _____

8D. Does the Veteran currently have any residuals 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 residuals or complications (brief summary), and also complete the appropriate questionnaire.

8E. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the diagnosis section, describe using the above format.

SECTION IX - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS AND SCARS

9A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the diagnosis section above?

◯ Yes ◯ No

If yes, describe. Brief summary:

9B. Does the Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis section?

◯ Yes ◯ No If yes, also complete the appropriate dermatological questionnaire

SECTION X - DIAGNOSTIC TESTING

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

10A. Has a biopsy been performed?

◯ Yes ◯ No

Date of biopsy: _____

Results:

10B. Are there any other significant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es) that were reviewed in conjunction with this examination?

◯ Yes ◯ No

If yes, provide type of test or procedure, date and results. Brief summary:

SECTION XI - FUNCTIONAL IMPACT

Note: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

11A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?

◯ Yes ◯ No

If yes, describe the functional impact of each condition, providing one or more examples:

SECTION XII - REMARKS

12A. Remarks (if any- please identify the section to which the remark pertains when appropriate).

SECTION XIII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

13A. Examiner's signature:	13B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

13C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	13D. Date Signed:

13E. Examiner's phone/fax numbers:	13F. National Provider Identifier (NPI) number:	13G. Medical license number and state:

13H. Examiner's address: