OMB Control No. 2900-0779
Respondent Burden: 15 minutes

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.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE EVER BEEN DIAGNOSED WITH A CONDITION OF THE MALE REPRODUCTIVE SYSTEM?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO MALE REPRODUCTIVE ORGAN CONDITIONS:

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1C. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO THE MALE REPRODUCTIVE ORGAN CONDITION(S), LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

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

SECTION III - FINDINGS, SIGNS AND SYMPTOMS

3A. DOES THE VETERAN HAVE ERECTILE DYSFUNCTION?

☐ YES ☐ NO

(If "Yes," is the erectile dysfunction as likely as not (at least 50% probability) attributable to MS (including treatment or residuals of treatment)

☐ YES ☐ NO

(If "No," provide the etiology of the erectile dysfunction): _____

(If "Yes," is the veteran able to achieve an erection (without medication) sufficient for penetration and ejaculation?)

☐ YES ☐ NO

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

☐ YES ☐ NO

3B. DOES THE VETERAN HAVE DEFORMITY OF THE PENIS *(such as Peyronie's disease)?*

☐ YES ☐ NO

(If "Yes,"describe):

3C. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING 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

3D. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING SIGNS AND/OR SYMPTOMS OF 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

SECTION III - FINDINGS, SIGNS AND SYMPTOMS *(Continued)*

3E. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING FINDINGS, SIGNS AND/OR SYMPTOMS OF OBSTRUCTED VOIDING?

☐ YES ☐ NO

(If "Yes,"check all signs and symptoms 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 or continuous catheterization

3F. DOES THE VETERAN HAVE VOIDING DYSFUNCTION REQUIRING THE USE OF AN APPLIANCE?

☐ YES ☐ NO *(If "Yes,"describe):*

3G. DOES THE VETERAN HAVE A HISTORY OF RECURRENT SYMPTOMATIC URINARY TRACT INFECTIONS, CHRONIC EPIDIDYMITIS, EPIDIDYMO-ORCHITIS AND/OR PROSTATITIS?

☐ YES ☐ NO

(If "Yes,"check all of the following treatment modalities that apply)

- ☐ No treatment
- ☐ Drainage
- ☐ Hospitalization
  - *(If checked, indicate frequency of hospitalization)*
  - ☐ 1 or 2 per year
  - ☐ More than 2 per year
- ☐ Intensive management
  - *(If checked, indicate frequency of management)*
  - ☐ Continuous
  - ☐ Intermittent
  - ☐ Long-term drug therapy

(If intensive management is checked, indicate treatment dates for courses of treatment): _____

_____

SECTION IV - OTHER CONDITIONS

4A. DOES THE VETERAN HAVE ANY PROSTATE CONDITIONS?

☐ YES ☐ NO

(If "Yes,"check all that apply)

- ☐ Benign prostatic hypertrophy
- ☐ Prostate injury
- ☐ Prostatitis
- ☐ Post-operative residuals

4B. DOES THE VETERAN HAVE ANY CONDITIONS OF THE URETHRA?

☐ YES ☐ NO

(If "Yes,"check all that apply)

- ☐ Urethral stricture
- ☐ Urethral fistula
- ☐ Multiple urethroperineal fistulas

4C. DOES THE VETERAN HAVE ANY NON-FUNCTIONING TESTES?

☐ YES, UNILATERAL ☐ YES, BILATERAL ☐ NO

SECTION V - EXAM

5A. PENIS EXAM

☐ NORMAL ☐ ABNORMAL

☐ NOT EXAMINED PER VETERAN'S REQUEST

☐ NOT EXAMINED; PENIS EXAM NOT RELEVANT TO CONDITION

(If abnormal is checked, indicate severity)

☐ Loss/removal of half or more of penis

☐ Loss/removal of glans penis

☐ Penis deformity: if checked, describe:

5B. TESTES EXAM

☐ NORMAL ☐ ABNORMAL

☐ NOT EXAMINED PER VETERAN'S REQUEST

☐ NOT EXAMINED; TESTICULAR EXAM NOT RELEVANT TO CONDITION

(If abnormal, check all that apply)

☐ Testicle is considerably harder than *(corresponding)* normal testicle

(If checked, indicate): ☐ Right ☐ Left ☐ Both

☐ Testicle is considerably softer than *(corresponding)* normal testicle

(If checked, indicate): ☐ Right ☐ Left ☐ Both

☐ Diameter of affected testicle reduced to one-half or less of *(corresponding)* normal testicle

(If checked, indicate): ☐ Right ☐ Left ☐ Both

☐ Diameter of affected testicle reduced to one-third of *(corresponding)* normal testicle

(If checked, indicate): ☐ Right ☐ Left ☐ Both

☐ Removal of testicle

(If checked, indicate): ☐ Right ☐ Left ☐ Both

☐ Congenitally undeveloped or undescended testicle

(If checked, indicate): ☐ Right ☐ Left ☐ Both

☐ Other, describe:

5C. PROSTATE EXAM

☐ NORMAL ☐ ABNORMAL

☐ NOT EXAMINED PER VETERAN'S REQUEST

☐ NOT EXAMINED; PROSTATE EXAM NOT RELEVANT TO CONDITION

(If abnormal, describe):

5D. EPIDIDYMIS EXAM

☐ NORMAL ☐ ABNORMAL

☐ NOT EXAMINED PER VETERAN'S REQUEST

☐ NOT EXAMINED; EPIDIDYMIS EXAM NOT RELEVANT TO CONDITION

☐ TENDERNESS TO PALPATION

(If checked, indicate): ☐ Right ☐ Left ☐ Both

(If abnormal, describe):

SECTION VI - NEOPLASM

6. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OF THE MALE REPRODUCTIVE SYSTEM?

☐ YES ☐ NO

(If "Yes,"complete the VA Form 21-0960J-3, Prostate Cancer Disability Benefits Questionnaire and VA Form 21-0960O-1, Tumors and Neoplasm, Disability Benefits Questionnaire)

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

7. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

☐ YES ☐ NO

(If "Yes," describe):

SECTION VIII - DIAGNOSTIC TESTING

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

8. HAS THE VETERAN HAD DIAGNOSTIC TESTING AND IF SO, ARE THERE SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

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

SECTION IX - FUNCTIONAL IMPACT AND REMARKS

9. DOES THE VETERAN'S MALE REPRODUCTIVE SYSTEM CONDITION(S) IMPACT HIS ABILITY TO WORK?

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

10. REMARKS *(If any)*

SECTION X - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

11A. PHYSICIAN'S SIGNATURE	11B. PHYSICIAN'S PRINTED NAME	11C. DATE SIGNED

11D. PHYSICIAN'S PHONE AND FAX NUMBER	11E. PHYSICIAN'S MEDICAL LICENSE NUMBER	11F. 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.vba.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 required to obtain or retain benefits. 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.