Department of Veterans Affairs

GYNECOLOGICAL CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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 questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

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

☐ Veteran/Claimant

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

1A. LIST THE CLAIMED GYNECOLOGICAL CONDITION(S) THAT PERTAIN TO THIS DBQ:

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 comments section. Date of diagnosis can be the date of evaluation if the clinician is making the initial diagnosis, or an approximate date determined through record review or reported history.

1B. LIST DIAGNOSES ASSOCIATED WITH THE CLAIMED 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):

☐ Mild pain	☐ Intermittent pain	☐ Constant pain
☐ Moderate pain	☐ Intermittent pain	☐ Constant pain
☐ Severe pain	☐ Intermittent pain	☐ Constant pain
☐ Pelvic pressure		

☐ Irregular menstruation
☐ Dysmenorrhea associated with ovarian dysfunction
☐ Secondary amenorrhea associated with ovarian dysfunction
☐ 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 FOR SYMPTOMS RELATED TO REPRODUCTIVE TRACT CONDITIONS?

☐ YES ☐ NO

(If yes, list current treatment and the reproductive organ conditions being treated):

SECTION IV - TREATMENT *(Continued)*

4C. IF YES, INDICATE EFFECTIVENESS OF TREATMENT IN CONTROLLING SYMPTOMS:

☐ Symptoms do not require continuous treatment for the following organ/condition: *(Check all that apply)*

- ☐ Conditions of the vulva or clitoris
- ☐ Conditions of the vagina
- ☐ Conditions of the cervix
- ☐ Conditions of the uterus
- ☐ Conditions of the fallopian tubes
- ☐ Conditions of the ovaries

☐ Symptoms require continuous treatment for the following organ/condition: *(Check all that apply)*

- ☐ Conditions of the vulva or clitoris
- ☐ Conditions of the vagina
- ☐ Conditions of the cervix
- ☐ Conditions of the uterus
- ☐ Conditions of the fallopian tubes
- ☐ Conditions of the ovaries

☐ Symptoms are not controlled by continuous treatment for the following organ/condition: *(Check all that apply)*

- ☐ Conditions of the vulva or clitoris
- ☐ Conditions of the vagina
- ☐ Conditions of the cervix
- ☐ Conditions of the uterus
- ☐ Conditions of the fallopian tubes
- ☐ Conditions of the ovaries

SECTION V - CONDITIONS OF THE VULVA OR CLITORIS

5. HAS THE VETERAN BEEN DIAGNOSED WITH ANY DISEASES, INJURIES OR OTHER CONDITIONS OF THE VULVA OR CLITORIS *(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 - REMOVAL OF THE OVARIES OR UTERUS

8A. HAS THE VETERAN HAD A HYSTERECTOMY?

☐ YES ☐ NO

(If yes, provide date(s) of surgery, facility(ies) where performed and cause):

8B. HAS THE VETERAN UNDERGONE PARTIAL OR COMPLETE OOPHORECTOMY?

☐ YES ☐ NO

(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):

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. 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)*

10C. 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

☐ 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?

☐ None ☐ One ☐ Multiple

(If one or more urethrovaginal fistulas, cause): _____

(If one or more urethrovaginal fistulas, 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 bleeding

☐ Irregular bleeding

☐ Lesions involving bowel confirmed by laparoscopy

☐ Lesions involving bladder confirmed by laparoscopy

☐ Bowel symptoms from endometriosis

☐ Bladder symptoms from endometriosis

☐ Anemia caused by endometriosis

☐ Other, describe: _____

(If yes, indicate effectiveness of treatment *in controlling symptoms)*:

☐ Symptoms of endometriosis do not require continuous treatment

☐ Symptoms of endometriosis require continuous treatment

☐ Symptoms of endometriosis are not controlled by continuous treatment

SECTION XIV - PELVIC ORGAN PROLAPSE

14A. DOES THE VETERAN HAVE ANY PELVIC ORGAN PROLAPSE DUE TO INJURY, DISEASE, OR SURGICAL COMPLICATIONS OF PREGNANCY?

☐ YES ☐ NO

(If yes, check all that apply):

☐ Bladder (cystocele)
☐ Urethra (urethrocele)
☐ Uterus (uterine prolapse)
☐ Vagina (vaginal vault prolapse)
☐ Small bowel (enterocele)
☐ Rectum (rectocele)

(If yes, indicate severity):

☐ Complete pelvic organ prolapse due to injury, disease, or surgical complications of pregnancy

☐ Incomplete pelvic organ prolapse due to injury, disease, or surgical complications of pregnancy

NOTE: Pelvic organ prolapse occurs when a pelvic organ such as bladder, urethra, uterus, vagina, small bowel, or rectum drops (prolapse) from its normal place in the abdomen. Conditions associated with pelvic organ prolapse include: Uterine or vaginal vault prolapse, cystocele, urethrocele, rectocele, enterocele, or any combination thereof.

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 THE DIAGNOSIS SECTION?

☐ YES ☐ NO *(If "Yes," also complete Items 15B through 15D)*

15B. IS THE NEOPLASM

☐ BENIGN ☐ MALIGNANT

(If malignant, indicate status of disease)

☐ Active

- ☐ Surgery, describe _____
- ☐ Antineoplastic chemotherapy
- ☐ Radiation
- ☐ Other, describe _____

Anticipated date of final treatment (surgical, antineoplastic, chemotherapy, or other _____

☐ Remission

- ☐ Surgery, describe _____
- ☐ Antineoplastic chemotherapy
- ☐ Radiation
- ☐ Other, describe _____

Anticipated date of final treatment (surgical, antineoplastic, chemotherapy, or other _____

SECTION XV - TUMORS AND NEOPLASMS *(Continued)*

15C. 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)*:

15D. 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 XVI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

16A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

IF YES, DESCRIBE (*brief summary*):

16B. 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 appropriate dermatological DBQ)

16C. COMMENTS, IF ANY:

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?

☐ 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 - FEMALE SEXUAL AROUSAL DISORDER (FSAD)

20. DOES THE VETERAN HAVE FSAD?

☐ YES ☐ NO

IF THE VETERAN HAS FSAD, IS IT AS LIKELY AS NOT (LIKELIHOOD IS AT LEAST APPROXIMATELY BALANCED OR NEARLY EQUAL, IF NOT HIGHER) ATTRIBUTABLE TO ONE OF THE DIAGNOSES IN SECTION I, INCLUDING RESIDUALS OF TREATMENT FOR THIS DIAGNOSIS?

☐ YES ☐ NO

IF THE VETERAN HAS SEXUAL DYSFUNCTION, IS SHE ABLE TO ACCOMPLISH AND/OR MAINTAIN AN AMPLE LUBRICATION-SWELLING REACTION DURING SEXUAL INTERCOURSE WITHOUT MEDICATION/TREATMENT?

☐ YES ☐ NO

IF NO, IS THE VETERAN CURRENTLY RECEIVING OR HAS SHE EVER RECEIVED MEDICATION/TREATMENT FOR FSAD?

☐ YES ☐ NO

IF YES, IS SHE ABLE TO ACCOMPLISH AND/OR MAINTAIN AN AMPLE LUBRICATION-SWELLING REACTION DURING SEXUAL INTERCOURSE WITH MEDICATION/TREATMENT?

☐ YES ☐ NO

SECTION XXI - EXAMINER'S CERTIFICATION AND SIGNATURE

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

21A. Examiner's signature:

21B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

21C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

21D. Date Signed:

21E. Examiner's phone/fax numbers:

21F. National Provider Identifier (NPI) number:

21G. Medical license number and state:

21H. Examiner's address: