

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 ON REVERSE 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 claim. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

IS THIS DBQ BEING COMPLETED IN CONJUNCTION WITH A VA21-2507, C&P EXAMINATION REQUEST?

YES NO

If no, how was the examination completed (check all that apply)?

- In-person examination
- Records reviewed
- Other, please specify:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

- Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the DBQ and such an examination will likely provide no additional relevant evidence.
- Review of available records in conjunction with a telephone interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with a telephone interview provided sufficient information on which to prepare the DBQ and such an examination would likely provide no additional relevant evidence.
- Examination via approved video telehealth
- In-person examination

EVIDENCE REVIEW

EVIDENCE REVIEWED (check all that apply):

- Not requested
- VA claims file (hard copy paper C-file)
- VA e-folder (VBMS or Virtual VA)
- CPRS
- Other (please identify other evidence reviewed):
- No records were reviewed

EVIDENCE COMMENTS:

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 gland injuries, infections, hypertrophy, post-operative residuals

Specify specific diagnosis: _____

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:

SECTION II - MEDICAL HISTORY (Continued)

2D. IS THERE ANY RENAL DYSFUNCTION DUE TO CONDITION?

YES NO

(If the Veteran has impaired kidney function, also complete VA Form 21-0960J-1, Kidney Conditions (Nephrology) Disability Benefits Questionnaire

SECTION III - VOIDING DYSFUNCTION

DOES THE VETERAN HAVE A VOIDING DYSFUNCTION?

YES NO *If yes, complete the following sections:*

3A. 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:

- | | |
|---|--|
| <input type="checkbox"/> Daytime voiding interval between 2 and 3 hours | <input type="checkbox"/> Nighttime awakening to void 2 times |
| <input type="checkbox"/> Daytime voiding interval between 1 and 2 hours | <input type="checkbox"/> Nighttime awakening to void 3 to 4 times |
| <input type="checkbox"/> Daytime voiding interval less than 1 hour | <input type="checkbox"/> 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 stream
If checked, is stream markedly slow?
 YES NO
- Weak stream
If checked, is stream markedly weak?
 YES NO
- Decreased force of stream
If checked, is force of stream markedly decreased?
 YES NO
- Obstructive symptomatology without stricture disease requiring dilatation one to two 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
- Marked obstructive symptomatology
- Urinary retention requiring intermittent catheterization
- Urinary retention requiring continuous catheterization
- Other, describe: _____

SECTION IV - ERECTILE DYSFUNCTION

DOES THE VETERAN HAVE ERECTILE DYSFUNCTION?

YES NO *If yes, complete the following section:*

4A. ETIOLOGY OF ERECTILE DYSFUNCTION: _____

4B. 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): _____

4C. IF THE VETERAN HAS ERECTILE DYSFUNCTION, IS HE ABLE TO ACHIEVE AN ERECTION SUFFICIENT FOR PENETRATION AND EJACULATION WITHOUT MEDICATION?

YES NO

If no, has the Veteran used medications for treatment of his erectile dysfunction?

YES NO

If yes, is the Veteran able to achieve an erection sufficient for penetration and ejaculation with medication?

YES NO

SECTION V - RETROGRADE EJACULATION

5A. DOES THE VETERAN HAVE RETROGRADE EJACULATION?

YES NO *If yes, complete Item 5B and provide etiology of retrograde ejaculation*

If yes, provide etiology of retrograde ejaculation: _____

5B. 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 retrograde ejaculation is as likely as not attributable: _____

SECTION VI - MALE REPRODUCTIVE ORGAN INFECTIONS

6. 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: _____

Recurrent symptomatic infection requiring drainage/frequent 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: _____

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 abnormal, indicate severity:

Loss/removal of less than half

Loss/removal of half or more of penis

Loss/removal of glans penis

Penis deformity (*such as Peyronie's disease*)

If checked, describe: _____

SECTION VII - PHYSICAL EXAM (Continued)

7B. 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

- Complete atrophy of
- 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

- Complete atrophy of
- 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: _____

7C. 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: _____

7D. PROSTATE

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

If abnormal, describe: _____

SECTION VIII - TUMORS AND NEOPLASMS

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 the following section:*

8A. IS THE NEOPLASM:

- BENIGN MALIGNANT
- Active
- In remission
- NA

SECTION VIII - TUMORS AND NEOPLASMS (Continued)

8B. 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: _____

8C. 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):*

8D. 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 AND/OR SYMPTOMS

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 (SURGICAL OR OTHERWISE) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES NO *If yes, are any of these scars painful or unstable*

If yes, are any of the scars painful and/or unstable, have a total area equal to or greater than 39 square cm (6 square inches), or are located on the head, face or neck? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

YES NO

If yes, also complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire.

If no, provide location and measurement of scar in centimeters.

Location: _____ Measurements: length _____ cm X width : _____ cm

NOTE: If there are multiple scars, enter additional locations and measurements in comments section below. It is not necessary to also complete a Scars DBQ.

9C. COMMENTS, IF ANY:

SECTION X - 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.

10A. HAS A TESTICULAR BIOPSY BEEN PERFORMED?

YES NO

Date of biopsy: _____

Results:

Spermatozoa present

Other, describe:

10 B. 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 XI - FUNCTIONAL IMPACT

11. 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 XII - REMARKS

12. REMARKS *(if any)*

SECTION XIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

13A. PHYSICIAN'S SIGNATURE

13B. PHYSICIAN'S PRINTED NAME

13C. DATE SIGNED

13D. PHYSICIAN'S PHONE AND FAX NUMBER

13E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

13F. 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.

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.