Department of Veterans Affairs

URINARY TRACT (INCLUDING BLADDER AND URETHRA) CONDITIONS (EXCLUDING MALE REPRODUCTIVE SYSTEM) 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 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 Veteran's claim.

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 OR SHE EVER BEEN DIAGNOSED WITH A CONDITION OF THE BLADDER OR URETHRA OF THE URINARY TRACT? *(This is the condition the Veteran is claiming or for which an exam has been requested)*

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO URINARY TRACT CONDITIONS OF THE BLADDER OR URETHRA:

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 DIAGNOSES THAT PERTAIN TO URINARY TRACT CONDITIONS OF THE BLADDER OR URETHRA, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S URINARY TRACT CONDITION *(brief summary):*

SECTION III - VOIDING DYSFUNCTION

3. DOES THE VETERAN HAVE A VOIDING DYSFUNCTION?

☐ YES ☐ NO *(If "Yes," complete the following section:)*

A. ETIOLOGY OF VOIDING DYSFUNCTION *(i.e., relationship of voiding dysfunction to any condition in the Diagnosis Section):*

B. DOES THE VOIDING DYSFUNCTION CAUSE URINE LEAKAGE?

☐ YES ☐ NO

(If "Yes," indicate severity)

- ☐ 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: _____

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

☐ YES ☐ NO *(If "Yes," describe the appliance):* _____

D. 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

E. 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

SECTION III - VOIDING DYSFUNCTION *(Continued)*

E. DOES THE VOIDING DYSFUNCTION CAUSE SIGNS OR SYMPTOMS OF OBSTRUCTED VOIDING? *(Continued)*

- ☐ Stricture disease
  - ☐ Does not require dilatation
  - ☐ Requires dilatation

    If checked, indicate frequency of periodic dilatation:

    ☐ 1 to 2 times per year ☐ Every 2 to 3 months ☐ Other, specify: _____
- ☐ 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 - UROLITHIASIS

4. DOES THE VETERAN HAVE A HISTORY OF URETHRAL OR BLADDER CALCULI *(cysto or urethrolithiasis)*?

☐ YES ☐ NO *(If "Yes," complete the following section):*

A. INDICATE LOCATION OF CALCULI *(check all that apply):*

☐ Urethra ☐ Bladder

B. HAS THE VETERAN HAD TREATMENT FOR RECURRENT STONE FORMATION IN THE URETHRA OR BLADDER?

☐ YES ☐ NO *(If "Yes," indicate treatment (check all that apply)):*

- ☐ Diet therapy *(If checked, specify diet:* _____ *and dates of use:* _____ *)*
- ☐ Drug therapy *(If checked, list medication:* _____ *and dates of use:* _____ *)*
- ☐ Invasive or non-invasive procedures *(If checked, indicate average number of times per year invasive or non-invasive procedures were required):*

  ☐ 0 to 1 per year ☐ 2 per year ☐ > 2 per year

  Provide name of facility and dates of most recent invasive or noninvasive procedure: _____

C. DOES THE VETERAN HAVE SIGNS OR SYMPTOMS DUE TO CYSTO- OR URETHROLITHIASIS?

☐ YES ☐ NO *(If "Yes," indicate type/severity (check all that apply)):*

- ☐ Bladder pain
- ☐ Dysuria
- ☐ Hematuria
- ☐ Voiding dysfunction
- ☐ Catheter drainage
  - ☐ Drainage required
  - ☐ Drainage not required
- ☐ Infections
  - ☐ Infections noted
  - ☐ No infections noted
- ☐ Sudden painful interruption of urinary stream
- ☐ Other, describe: _____

SECTION V - BLADDER OR URETHRAL INFECTION

5. DOES THE VETERAN HAVE A HISTORY OF RECURRENT SYMPTOMATIC BLADDER OR URETHRAL INFECTIONS?

☐ YES ☐ NO *(If "Yes," complete the following section;)*

A. PROVIDE ETIOLOGY *(i.e., relationship of recurrent symptomatic bladder or urethral infections to any condition in Section I, Diagnosis):*

_____

B. IF THE VETERAN HAS HAD RECURRENT SYMPTOMATIC URETHRAL OR BLADDER INFECTIONS, INDICATE ALL TREATMENT MODALITIES 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
- ☐ 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 VI - OTHER BLADDER/URETHRAL CONDITIONS

A. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO A BLADDER FISTULA?

☐ YES ☐ NO

Does the Veteran have Suprapubic Cystotomy?

☐ YES ☐ NO

B. DOES THE VETERAN HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO A URETHRAL FISTULA?

☐ YES ☐ NO

Does the Veteran have multiple urethroperineal fistulae?

☐ YES ☐ NO

C. DOES THE VETERAN HAVE A NEUROGENIC OR A SEVERELY DYSFUNCTIONAL BLADDER?

☐ YES ☐ NO

If yes, describe:

D. DOES THE VETERAN HAVE A BLADDER INJURY?

☐ YES ☐ NO

If yes, describe:

E. HAS THE VETERAN HAD OTHER BLADDER SURGERY ?

☐ YES ☐ NO

If yes, describe:

F. IS THERE ANY RENAL DYSFUNCTION DUE TO CONDITION?

☐ YES ☐ NO

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

SECTION VII - TUMORS AND NEOPLASMS

7. 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:)*

A. IS THE NEOPLASM

☐ BENIGN ☐ MALIGNANT

☐ Active ☐ In remission

B. 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: _____ and provide date(s) of surgery: _____*

☐ Radiation therapy *(If checked, provide date of most recent treatment: _____ and provide date of completion of treatment or anticipated date of completion: _____)*

☐ Antineoplastic chemotherapy *(If checked, provide date of most recent treatment: _____ and provide date of completion of treatment or anticipated date of completion: _____)*

☐ Other therapeutic procedure *(If checked, describe procedure: _____ and provide date of most recent procedure: _____)*

☐ Other therapeutic treatment *(If checked, describe treatment: _____ and provide date of completion of treatment or anticipated date of completion: _____)*

SECTION VII - TUMORS AND NEOPLASMS *(continued)*

C. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM *(including metastases)* OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED ON THIS QUESTIONNAIRE?

☐ YES ☐ NO *(If "Yes," list residual conditions and complications (brief summary)):*

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

8A. 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*):

8B. 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; 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.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION: _____ MEASUREMENTS: length _____ cm X width _____ cm.

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

8C. COMMENTS, IF ANY:

SECTION IX - DIAGNOSTIC TESTING

NOTE: If diagnostic test results are in the medical record and reflect the Veteran's current urinary tract condition, repeat testing is not required.

9. HAS THE VETERAN HAD 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 X - FUNCTIONAL IMPACT

10. DOES THE VETERAN'S CONDITION(S) OF THE BLADDER OR URETHRA IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of each of the Veteran's bladder or urethra condition(s), providing one or more examples):*

SECTION XI - REMARKS

11. 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.

12A. PHYSICIAN'S SIGNATURE	12B. PHYSICIAN'S PRINTED NAME	12C. DATE SIGNED

12D. PHYSICIAN'S PHONE AND FAX NUMBERS	12E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	12F. 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.