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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 BEFORE COMPLETING THIS FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

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

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)*

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 appropriate date determined through record review or reported history.

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 RECORD REVIEW

2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARATION OF THIS REPORT:

☐ C-FILE (VA ONLY)

☐ OTHER, DESCRIBE: _____

SECTION III - MEDICAL HISTORY

3A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S URINARY TRACT CONDITION *(brief summary):*

3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S URINARY TRACT CONDITION?

☐ YES ☐ NO *(If "Yes," list only those medications required for the veteran's urinary tract condition):*

SECTION IV - VOIDING DYSFUNCTION

4. DOES THE VETERAN HAVE A VOIDING DYSFUNCTION?

☐ YES ☐ NO *(If "Yes," complete Items 4A thru 4E):*

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

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

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV - VOIDING DYSFUNCTION *(Continued)*

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 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 *(If checked, indicate frequency of periodic dilation):*
  - ☐ 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
- ☐ Urinary retention requiring intermittent catheterization
- ☐ Urinary retention requiring continuous catheterization
- ☐ Other, describe: _____

SECTION V - UROLITHIASIS

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

☐ YES ☐ NO *(If "Yes," complete Items 5A thru 5C):*

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 URETHROLITHIASIS?

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

- ☐ Bladder pain
- ☐ Dysuria
- ☐ Hematuria
- ☐ Voiding dysfunction
- ☐ Requirement for catheter drainage
- ☐ Sudden painful interruption of urinary stream
- ☐ Other, describe: _____

SECTION VI - BLADDER OR URETHRAL INFECTION

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

☐ YES ☐ NO *(If "Yes," complete Items 6A & 6B)*

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: _____

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SECTION VII - OTHER BLADDER/URETHRAL CONDITIONS

7. DOES THE VETERAN NOW HAVE OR HAS THE VETERAN EVER HAD A BLADDER OR URETHRAL FISTULA, STRICTURE, NEUROGENIC BLADDER, BLADDER INJURY OR OTHER BLADDER SURGERY?

☐ YES ☐ NO *(If "Yes," complete Items 7A thru 7E):*

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

☐ YES ☐ NO

(If "Yes," check all that apply):

☐ Voiding dysfunction *(urine leakage, obstructed voiding)*

☐ Requirement for catheter drainage

☐ Infection *(cystitis or urethritis)*

☐ Impaired kidney function

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

☐ Other, describe: _____

B. HAS THE VETERAN HAD SURGERY FOR A BLADDER OR URETHRAL FISTULA?

☐ YES ☐ NO

(If "Yes," indicate surgical treatment):

☐ None

☐ Resection or closure of fistula *(If checked, provide date of treatment and name of treatment facility: _____)*

☐ Urinary diversion *(If checked, provide date of treatment and name of treatment facility: _____)*

☐ Partial bladder resection *(If checked, provide date of treatment and name of treatment facility: _____)*

☐ Other, describe: _____ *(If checked, provide date of treatment and name of treatment facility: _____)*

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):*

SECTION VIII - TUMORS AND NEOPLASMS

8. 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 Items 8A through 8D)*

A. IS THE NEOPLASM

☐ BENIGN ☐ MALIGNANT

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: _____)*

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:

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

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

9A. 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?

☐ YES ☐ NO

IF "YES," ARE ANY OF THESE 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?

☐ YES ☐ NO

IF "YES," ALSO COMPLETE VA FORM 21-0960F-1, *SCARS/DISFIGUREMENT DISABILITY BENEFITS QUESTIONNAIRE (DBQ)*.

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

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

NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in the "Remarks" section. It is not necessary to also complete a Scars/Disfigurement DBQ.

9B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

☐ YES ☐ NO *(If "Yes," describe (brief summary)):*

SECTION X - 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.

10. 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 XI - FUNCTIONAL IMPACT

11. 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 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/FAX NUMBERS	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.

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.benefits.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 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.