

**URINARY TRACT (INCLUDING BLADDER AND URETHRA) CONDITIONS  
(EXCLUDING MALE REPRODUCTIVE SYSTEM) DISABILITY BENEFITS QUESTIONNAIRE**

Name of Claimant/Veteran:	Claimant/Veteran's Social Security Number:	Date of examination:
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**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 th 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 condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. Does the Veteran currently have, or have they ever been diagnosed with, a urinary tract condition of the bladder or urethra?  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 approximate 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 HISTORY**

2A. Describe the history (including onset and course) of the Veteran's urinary tract condition - brief summary:

**SECTION III - VOIDING DYSFUNCTION**

3A. Does the Veteran have a voiding dysfunction?  Yes  No If yes, complete 3B - 3F.

3B. Etiology of voiding dysfunction, if known:

**SECTION III - VOIDING DYSFUNCTION (continued)**

3C. 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: \_\_\_\_\_

3D. Does the voiding dysfunction require the use of an appliance?  Yes  No If yes, describe the appliance: \_\_\_\_\_

3E. Does the voiding dysfunction cause increased urinary frequency?  Yes  No If yes, check all that apply:

- Daytime voiding interval less than 1 hour
- Daytime voiding interval between 1 and 2 hours
- Daytime voiding interval between 2 and 3 hours
- Nighttime awakening to void 2 times
- Nighttime awakening to void 3 to 4 times
- Nighttime awakening to void 5 or more times

3F. Does the voiding dysfunction cause signs or symptoms of obstructed voiding?  Yes  No If yes, check all that apply:

- Hesitancy
- Slow stream
- Weak stream
- Decreased force of stream
- Other Describe: \_\_\_\_\_
- Urinary retention requiring intermittent catheterization
- Urinary retention requiring continuous catheterization
- Uroflowmetry peak flow rate less than 10 cc/sec
- Post void residuals greater than 150 cc
- Recurrent urinary tract infections secondary to obstruction
- Stricture disease If selected, indicate frequency of periodic dilatation:
  - Does not require dilatation
  - Requires dilatation
    - 1 to 2 times per year
    - Every 2 to 3 months
    - Other, specify: \_\_\_\_\_

**SECTION IV - UROLITHIASIS**

4A. Does the Veteran have a history of bladder calculi (cystolithiasis) or urethral calculi (urethrolithiasis)?  Yes  No If yes, complete 4B - 4D.

4B. Indicate location of calculi - check all that apply:

- Bladder
- Urethra

4C. Has the Veteran had treatment for recurrent stone formation in the bladder or urethra?  Yes  No If yes, indicate treatment - check all that apply:

- Invasive or non-invasive procedures two times or less per year
- Invasive or non-invasive procedures more than two times per year
- Diet therapy
- Drug therapy

4D. Does the Veteran have signs or symptoms due to cystolithiasis or urethrolithiasis?  Yes  No If yes, indicate type/severity - check all that apply:

- Infection
- Voiding dysfunction
- Impaired kidney function\* If selected, also complete the appropriate questionnaire.
- Occasional attacks of colic
- Frequent attacks of colic
- Is catheter drainage required?
  - Yes
  - No

\*For VA purposes, renal dysfunction includes evidence demonstrating the following for at least 3 consecutive months during the past 12 months: glomerular filtration rate (GFR) of less than 60 mL/min/1.73m<sup>2</sup>; or GFR from 60 to 89 mL/min/1.73m<sup>2</sup> and the presence of at least one of the following: recurrent red blood cell (RBC) casts, white blood cell (WBC) casts, granular casts, structural kidney abnormalities (cystic, obstructive, or glomerular), or increased secretion of protein in the urine (proteinuria). GFR, estimated GFR (eGFR), and creatinine based approximations of GFR will be accepted for evaluation purposes when determined to be appropriate and calculated by a medical professional. Note: If the medical record contains multiple lab tests during this 12 month period, separated by at least 3 months, and there is no evidence to contradict those findings in the interim period, VA will accept that the demonstrated renal dysfunction has persisted for at least 3 consecutive months during the past 12 months.

Other Describe: \_\_\_\_\_

**SECTION V - BLADDER OR URETHRAL INFECTION**

5A. Does the Veteran have a history of recurrent, symptomatic bladder or urethral infections?  Yes  No If yes, complete 5B & 5C:

5B. Etiology of bladder or urethral infections, if known: \_\_\_\_\_

5C. If the Veteran has had recurrent, symptomatic urethral or bladder infections, indicate all treatment modalities that apply:

- No treatment
- Suppressive drug therapy If checked, list medications used and indicate dates for courses of treatment over the past 12 months: \_\_\_\_\_
  - Lasting 6 months or longer
  - For less than 6 months
- Hospitalization If checked, indicate frequency of hospitalizations:  1 or 2 per year  More than 2 per year
- Drainage by stent or nephrostomy tube If checked, indicate dates drainage was performed over the past 12 months: \_\_\_\_\_
- Continuous intensive management required. If checked, indicate types of treatment and medications used over the past 12 months: \_\_\_\_\_
- Recurrent symptomatic infection
- Other Describe: \_\_\_\_\_

**SECTION VI - OTHER BLADDER OR URETHRAL CONDITIONS**

- 6A. Does the Veteran have any findings, signs, or symptoms attributable to a bladder fistula?  Yes  No If yes, describe in Comment box below (6J).
- 6B. Does the Veteran have any findings, signs, or symptoms attributable to diverticulum of the bladder?  Yes  No If yes, describe in Comment box below (6J).
- 6C. Does the Veteran have suprapubic cystotomy?  Yes  No If yes, provide name of facility and date of procedure in Comment box below (6J).
- 6D. Does the Veteran have any findings, signs, or symptoms attributable to a urethral fistula?  Yes  No If yes, describe in Comment box below (6J).
- 6E. Does the Veteran have multiple urethroperineal fistulae?  Yes  No If yes, describe in Comment box below (6J).
- 6F. Does the Veteran have a neurogenic or severely dysfunctional bladder?  Yes  No If yes, describe in Comment box below (6J).
- 6G. Does the Veteran have a history of bladder injury?  Yes  No If yes, describe in Comment box below (6J).
- 6H. Has the Veteran had other bladder surgery?  Yes  No If yes, describe in Comment box below (6J).
- 6I. Is there any renal dysfunction\* due to a condition noted in this section?  Yes  No If yes, also complete the appropriate questionnaire.

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6J. Comments (if any, please identify the question number to which the comment pertains):

**SECTION VII - TUMORS AND NEOPLASMS**

- 7A. Does the Veteran currently have, or has had, a benign or malignant neoplasm or metastases related to any condition in the Diagnosis Section?  
 Yes  No If yes, complete 7B - 7E:
- 7B. The neoplasm is:  Benign  
 Malignant - if malignant, select all that apply:  
 In remission  Active  
 Primary  Secondary (metastatic) If secondary, indicate the primary site if known:
- 7C. 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  
 Surgery - If selected, specify type of surgery: \_\_\_\_\_ and date of surgery: \_\_\_\_\_  
 Radiation therapy - If selected, specify:  
Date of completion of most recent treatment: \_\_\_\_\_ or anticipated completion date of current treatment:   
 Antineoplastic chemotherapy - If selected, specify:  
Date of completion of most recent treatment:  or anticipated completion date of current treatment:   
 Other therapeutic procedure - If selected, specify type of procedure: \_\_\_\_\_ and date of procedure: \_\_\_\_\_  
 Other therapeutic treatment - If selected, specify:  
Type of treatment:  Date of completion or anticipated date of completion:
- 7D. Does the Veteran currently have any residuals 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 residuals or complications (brief summary), and also complete the appropriate questionnaire:

7E. 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 VIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS**

8A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs, and/or symptoms related to any of the conditions listed in the Diagnosis Section?  Yes  No If yes, describe - brief summary:

8B. Does the Veteran have any scars or other disfigurement of the skin related to any of the conditions, or to the treatment of any of the conditions, listed in the Diagnosis Section?  Yes  No If yes, also complete the appropriate dermatological questionnaire.

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.

9A. Has the Veteran had diagnostic testing in conjunction with this exam?

Yes  No If yes, provide significant findings and/or results (type of test or procedure, date and results) - brief summary:

9B. Are there any other significant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

Yes  No If yes, provide type of test or procedure, date and results - brief summary:

**SECTION X - FUNCTIONAL IMPACT**

Note: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

10A. Does the Veteran's condition 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**

11A. Remarks (if any, please identify the section to which the remark pertains when appropriate):

**SECTION XII - EXAMINER'S CERTIFICATION AND SIGNATURE**

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

12A. Examiner's signature:

12B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

12C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

12D. Date Signed:

12E. Examiner's phone/fax numbers:

12F. National Provider Identifier (NPI) number:

12G. Medical license number and state:

12H. Examiner's address: