



## **Compensation and Pension Record Interchange (CAPRI)**

# **Male Reproductive System Conditions Disability Benefits Questionnaire (DBQ) Workflow**

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Department of Veterans Affairs  
Office of Enterprise Development  
Management & Financial Systems

## Revision History

Date	Description (Patch # if applicable)	Author	Technical Writer
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4/7/11	Changed mandatory logic to “Please describe the appliance used for the voiding dysfunction.”  Changed If yes, describe: to If yes, describe the appliance	K. DeLaCruz	N/A

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# 1 Introduction

## 1.1 Purpose

This document provides a high level overview of the contents found on the Male Reproductive System Conditions Disability Benefits Questionnaire (DBQ). The DBQ can be populated via an online template within the CAPRI C&P Worksheets tab and then printed OR it can be printed via AMIE (AUTOMATED MEDICAL INFORMATION EXCHANGE) and then manually populated. This document contains the edit rules for the template as well as an example of how the template will look online in CAPRI or printed from CAPRI. It also contains the layout for the AMIE worksheet to depict how it will look when printed from AMIE.

For more detailed information on standard template functionality not covered in this document, please refer to the *C&P Worksheet Tab Functionalities* section of the [CAPRI GUI User Guide](#).

## 1.2 Overview

The Male Reproductive System Conditions DBQ provides the ability to capture information related to Male Reproductive Organs and its treatment.

Each DBQ template contains a standard footer containing a note stating that “VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.” (see Figure 1 and 2).

**Figure 1: Template Example: DBQ - Standard VA Note**

**NOTE:** VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

**Figure 2: Print Example: DBQ – Standard VA Note**

**NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.**

A number of fields on the Male Reproductive System Conditions DBQ are mandatory and require a response (value) prior to the exam being marked as completed. Some questions may activate a Pop-up window displaying information as to each question that needs to be answered before the template can be completed.

## 2 Male Reproductive System Conditions DBQ

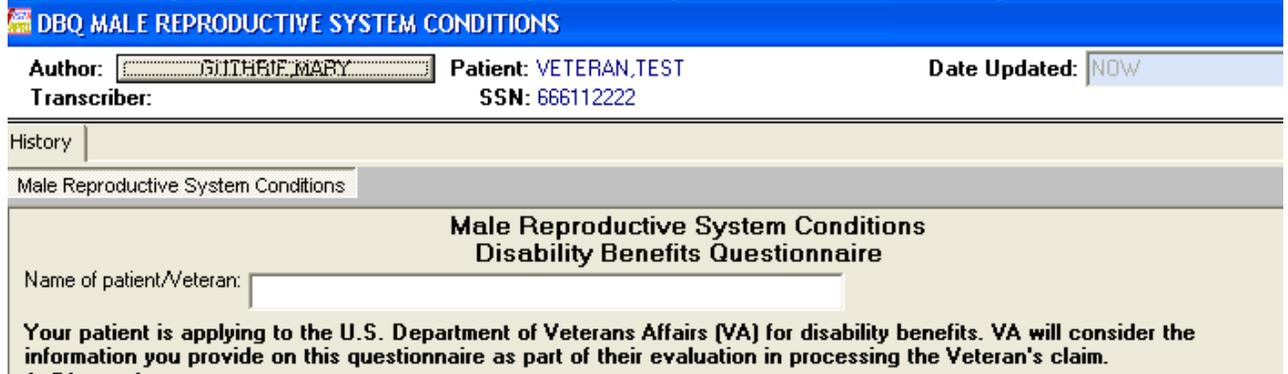
### 2.1 Name of patient/Veteran

All questions in this section may be answered as described by the rules below. If mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

**Table 1: Rules: DBQ – Male Reproductive System Conditions – Name of patient/Veteran**

Field/Question	Field Disposition	Valid Values	Format	Error Message
Male Reproductive System Conditions	Enabled, Read-Only	N/A	N/A	N/A
Disability Benefits Questionnaire	Enabled, Read-Only	N/A	N/A	N/A
Name of patient/Veteran:	Enabled, Mandatory	N/A	Free Text	Please enter the name of the patient/Veteran.
<b>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.</b>	Enabled, Read-Only	N/A	N/A	N/A

**Figure 3: Template Example: DBQ – Male Reproductive System Conditions – Name of patient/Veteran**



**DBQ MALE REPRODUCTIVE SYSTEM CONDITIONS**

Author: GUTHRIE, MARY Patient: VETERAN, TEST Date Updated: NOW  
 Transcriber: SSN: 666112222

History

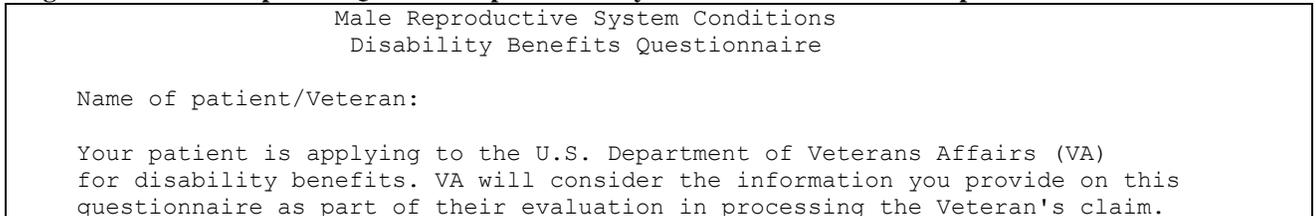
Male Reproductive System Conditions

**Male Reproductive System Conditions  
 Disability Benefits Questionnaire**

Name of patient/Veteran:

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.

**Figure 4: Print Example: DBQ – Male Reproductive System Conditions – Name of patient/Veteran**



Male Reproductive System Conditions  
 Disability Benefits Questionnaire

Name of patient/Veteran:

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.

## 2.2 Section 1. Diagnosis

The question “Does the Veteran now have or has he ever been diagnosed with any conditions of the male reproductive system?” must be answered before the template can be completed.

- If it is answered with Yes, all other questions requiring an answer as described by the rules in this document must be answered before the template can be completed.
- If it is answered with No, the rationale must be completed. The remainder of the template may be completed without answering any additional questions or the user may input answers to any of the optional questions as indicated by the rules described in this document.

All questions will be printed even if they have not been answered.

If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below and must be answered before this template can be completed.

**Table 2: Rules: DBQ – Male Reproductive System Conditions – 1. Diagnosis**

Field/Question	Field Disposition	Valid Values	Format	Error Message
<b>1.Diagnosis</b>	Enabled, Read-Only	N/A	N/A	N/A
Does the Veteran now have or has he ever been diagnosed with any conditions of the male reproductive system?	Enabled, Mandatory; Choose one valid value	[Yes; No]	N/A	Please answer the question: Does the Veteran now have or has he ever been diagnosed with any conditions of the male reproductive system?
If no, provide rationale (e.g., Veteran has never had any known male reproductive organ conditions):	If <i>Does the Veteran now have or has he ever been diagnosed with any conditions of the male reproductive system? = No</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please provide the rationale for indicating the Veteran has not been diagnosed with a condition of the male reproductive system.

Field/Question	Field Disposition	Valid Values	Format	Error Message
If yes, indicate diagnoses (check all that apply):	<p>If <i>Does the Veteran now have or has he ever been diagnosed with any conditions of the male reproductive system?</i> = Yes;            Enabled, Mandatory;            Choose one or more valid values</p> <p>Else; Enabled, Optional</p>	[Erectile dysfunction; Penis, deformity (e.g., Peyronie's); Testis, atrophy, one or both; Testis, removal, one or both; Epididymitis, chronic; Epididymo-orchitis, chronic; Prostate injury; prostate hypertrophy (BPH); Prostatitis, chronic; Prostate surgical residuals (as addressed in items 3-6); Neoplasms of the male reproductive system; Other male reproductive system condition (specify diagnosis, providing only diagnoses that pertain to male reproductive system)]	N/A	Please indicate the Veteran's male reproductive system diagnosis.
ICD Code:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Erectile dysfunction</i>;            Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Erectile dysfunction</i>;            Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the ICD code for Erectile dysfunction.

Field/Question	Field Disposition	Valid Values	Format	Error Message
Date of Diagnosis:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Erectile dysfunction</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Erectile dysfunction</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the date of diagnosis for Erectile dysfunction.
ICD Code:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Penis, deformity (e.g. Peyronie's)</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Penis, deformity (e.g. Peyronie's)</i>.; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the ICD code for Penis, deformity (e.g. Peyronie's).
Date of Diagnosis:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Penis, deformity (e.g. Peyronie's)</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Penis, deformity (e.g. Peyronie's)</i>.; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the date of diagnosis for Penis, deformity (e.g. Peyronie's).
ICD Code:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Testis, atrophy, one or both</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Testis, atrophy, one or both</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the ICD code for Testis, atrophy, one or both.

Field/Question	Field Disposition	Valid Values	Format	Error Message
Date of Diagnosis:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Testis, atrophy, one or both</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Testis, atrophy, one or both</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the date of diagnosis for Testis, atrophy, one or both.
ICD Code:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Testis, removal, one or both</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Testis, removal, one or both</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the ICD code for Testis, removal, one or both.
Date of Diagnosis:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Testis, removal, one or both</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Testis, removal, one or both</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the date of diagnosis for Testis, removal, one or both.
ICD Code:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Epididymitis, chronic</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Epididymitis, chronic</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the ICD code for Epididymitis, chronic.

Field/Question	Field Disposition	Valid Values	Format	Error Message
Date of Diagnosis:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Epididymitis, chronic</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Epididymitis, chronic</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the date of diagnosis for Epididymitis, chronic.
ICD Code:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Epididymo-orchitis, chronic</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Epididymo-orchitis, chronic</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the ICD code for Epididymo-orchitis, chronic.
Date of Diagnosis:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Epididymo-orchitis, chronic</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Epididymo-orchitis, chronic</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the date of diagnosis for Epididymo-orchitis, chronic.
ICD Code:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Prostate injury</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Prostate injury</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the ICD code for Prostate injury.

Field/Question	Field Disposition	Valid Values	Format	Error Message
Date of Diagnosis:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Prostate injury</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Prostate injury</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the date of diagnosis for Prostate injury.
ICD Code:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Prostate hypertrophy (BPH)</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Prostate hypertrophy (BPH)</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the ICD code for Prostate hypertrophy (BPH).
Date of Diagnosis:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Prostate hypertrophy (BPH)</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Prostate hypertrophy (BPH)</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the date of diagnosis for Prostate hypertrophy (BPH).
ICD Code:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Prostatitis, chronic</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Prostatitis, chronic</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the ICD code for Prostatitis, chronic.

Field/Question	Field Disposition	Valid Values	Format	Error Message
Date of Diagnosis:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Prostatitis, chronic</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Prostatitis, chronic</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the date of diagnosis for Prostatitis, chronic.
ICD Code:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Prostate surgical residuals</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Prostate surgical residuals</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the ICD code for Prostate surgical residuals (as addressed in items 3-6).
Date of Diagnosis:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Prostate surgical residuals</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Prostate surgical residuals</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the date of diagnosis for Prostate surgical residuals (as addressed in items 3-6).
ICD Code:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Neoplasms of the male reproductive system</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Neoplasms of the male reproductive system</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the ICD code for Neoplasms of the male reproductive system.

Field/Question	Field Disposition	Valid Values	Format	Error Message
Date of Diagnosis:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Neoplasms of the male reproductive system</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Neoplasms of the male reproductive system</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the date of Neoplasms of the male reproductive system.
ICD Code:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Other male reproductive system condition (specify diagnosis, providing only diagnoses that pertain to male reproductive system.)</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Other male reproductive system condition (specify diagnosis, providing only diagnoses that pertain to male reproductive system.)</i>; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the ICD code for Other male reproductive system condition (specify diagnosis, providing only diagnoses that pertain to male reproductive system).

<b>Field/Question</b>	<b>Field Disposition</b>	<b>Valid Values</b>	<b>Format</b>	<b>Error Message</b>
Date of Diagnosis:	<p>If <i>Diagnosis = Yes</i> and if <i>Diagnosis includes Other male reproductive system condition (specify diagnosis, providing only diagnoses that pertain to male reproductive system.);</i> Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and if <i>Diagnosis includes Other male reproductive system condition (specify diagnosis, providing only diagnoses that pertain to male reproductive system.);</i> Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please enter the date of Other male reproductive system condition (specify diagnosis, providing only diagnoses that pertain to male reproductive system.
Other diagnosis #1:	Enabled, Optional	N/A	Free Text	N/A
ICD code:	<p>If <i>Diagnosis = Yes</i> and <i>Other diagnosis #1 is populated;</i> Enabled, Mandatory</p> <p>Else; Enabled, Optional</p>	N/A	Free Text	Please enter the ICD code for other diagnosis #1.
Date of diagnosis:	<p>If <i>Diagnosis = Yes</i> and <i>Other diagnosis #1 is populated;</i> Enabled, Mandatory</p> <p>Else; Enabled, Optional</p>	N/A	Free Text	Please enter the date of other diagnosis #1.
Other diagnosis #2:	Enabled, Optional	N/A	Free Text	N/A
ICD code:	<p>If <i>Diagnosis = Yes</i> and <i>Other diagnosis #2 is populated;</i> Enabled, Mandatory</p> <p>Else; Enabled, Optional</p>	N/A	Free Text	Please enter the ICD code for other diagnosis #2.
Date of diagnosis:	<p>If <i>Diagnosis = Yes</i> and <i>Other diagnosis #2 is populated;</i> Enabled, Mandatory</p> <p>Else; Enabled, Optional</p>	N/A	Free Text	Please enter the date of other diagnosis #2.

Field/Question	Field Disposition	Valid Values	Format	Error Message
If there are additional diagnoses that pertain to the male reproductive organ conditions, list using above format:	Enabled, Optional	N/A	Free Text	N/A

**Figure 5: Template Example: DBQ – Male Reproductive System Conditions – 1. Diagnosis**

**1. Diagnosis**  
 Does the Veteran now have or has he ever been diagnosed with a condition of the male reproductive system?  
 Yes  No

If no, provide rationale/reason (e.g., Veteran does not currently have any known male reproductive organ conditions):  
 \_\_\_\_\_

If yes, indicate diagnosis: (check all that apply)

<input checked="" type="checkbox"/> Erectile dysfunction	ICD Code: _____	Date: _____
<input checked="" type="checkbox"/> Penis, deformity (e.g., Peyronie's)	ICD Code: _____	Date: _____
<input checked="" type="checkbox"/> Testis, atrophy, one or both	ICD Code: _____	Date: _____
<input checked="" type="checkbox"/> Testis, removal, one or both	ICD Code: _____	Date: _____
<input checked="" type="checkbox"/> Epididymitis, chronic	ICD Code: _____	Date: _____
<input checked="" type="checkbox"/> Epididymo-orchitis, chronic	ICD Code: _____	Date: _____
<input checked="" type="checkbox"/> Prostate injury	ICD Code: _____	Date: _____
<input checked="" type="checkbox"/> Prostate hypertrophy (BPH)	ICD Code: _____	Date: _____
<input checked="" type="checkbox"/> Prostatitis, chronic	ICD Code: _____	Date: _____
<input checked="" type="checkbox"/> Prostate surgical residuals (as addressed in items 3-6)	ICD Code: _____	Date: _____
<input checked="" type="checkbox"/> Neoplasms of the male reproductive system	ICD Code: _____	Date: _____
<input checked="" type="checkbox"/> Other male reproductive system condition (specify diagnosis, providing only diagnoses that pertain to male reproductive system.)	ICD Code: _____	Date: _____

Other diagnosis #1: \_\_\_\_\_

ICD code: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

Other diagnosis #2: \_\_\_\_\_

ICD code: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

If there are additional diagnoses that pertain to the male reproductive organ conditions, list using above format:  
 \_\_\_\_\_

**Figure 6: Print Example: DBQ – Male Reproductive System Conditions – 1. Diagnosis**

1. Diagnosis  
 -----  
 Does the Veteran now have or has he ever been diagnosed with any conditions of the male reproductive system? [X] Yes [ ] No

If no, provide rationale (e.g., Veteran has never had any known male reproductive organ conditions):

If yes, 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 injury  
     ICD Code:                      Date of Diagnosis:

[ ] Prostate hypertrophy (BPH)  
     ICD Code:                      Date of Diagnosis:

[ ] Prostatitis, chronic  
     ICD Code:                      Date of Diagnosis:

[ ] Prostate surgical residuals (as addressed in items 3-6)  
     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 male reproductive system.)  
     ICD Code:                      Date of Diagnosis:

Other diagnosis #1:  
     ICD code:  
     Date of diagnosis:

Other diagnosis #2:  
     ICD code:  
     Date of diagnosis:

If there are additional diagnoses that pertain to the male reproductive  
 organ conditions, list using above format:

### 2.3 Section 2. Medical history

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

**Table 3: Rules: DBQ – Male Reproductive System Conditions – 2. Medical history**

Field/Question	Field Disposition	Valid Values	Format	Error Message
<b>2. Medical history</b>	Enabled; Read Only	N/A	N/A	N/A
a. Describe the history (including onset and course) of the Veteran's male reproductive organ condition(s) (brief summary):	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory  Else; Enabled, Optional	N/A	Free Text	Please describe the history (including onset and course) of the Veteran's current male reproductive organ condition(s).
b. Does the Veteran's treatment plan include taking continuous medication for the diagnosed condition?	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory  Else; Enabled, Optional  Choose one valid value.	[Yes; No]	N/A	Please provide an answer to the question: Does the Veteran's treatment plan include taking continuous medication for the diagnosed condition?
List Medications:	If <i>Diagnosis = Yes</i> and <i>Does the Veteran's treatment plan include taking continuous medication for the diagnosed condition? = Yes</i> ; Enabled, Mandatory  If <i>Diagnosis = No</i> and <i>Does the Veteran's treatment plan include taking continuous medication for the diagnosed condition? = Yes</i> ; Enabled, Optional  Else; Disabled	N/A	Free Text	Please list continuous medications taken for the diagnosed condition.
c. Has the Veteran had an orchiectomy?	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory  Else; Enabled, Optional  Choose one valid value	[Yes; No]	N/A	Please provide an answer to the question: Has the Veteran had an orchiectomy?
Indicate testicle removed:	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> and <i>Has the Veteran had an orchiectomy? = Yes</i> ; Enabled, Mandatory  If <i>Diagnosis = No</i> and <i>Has</i>	[Right; Left; Both]	N/A	Please indicate which testicle was removed.

	<p><i>the Veteran had an orchiectomy?</i> = Yes; Enabled, Optional</p> <p>Choose one valid value</p> <p>Else; Disabled</p>			
Indicate reason for removal:	<p>If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> and <i>Has the Veteran had an orchiectomy?</i> = Yes; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and <i>Has the Veteran had an orchiectomy?</i> = Yes; Enabled, Optional</p> <p>Choose one valid value</p> <p>Else; Disabled</p>	[Undescended; Congenitally underdeveloped; Other: provide reason for removal:]	N/A	Please indicate the reason for the orchiectomy.
Other: provide reason for removal:	<p>If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> and <i>Reason for removal = Other</i>; Enabled, Mandatory</p> <p>If <i>Diagnosis = No</i> and <i>Has the Veteran had an orchiectomy?</i> = Yes; Enabled, Optional</p> <p>Else; Disabled</p>	N/A	Free Text	Please provide the other reason for the orchiectomy.

**Figure 7: Template Example: DBQ – Male Reproductive System Conditions – 2. Medical history**

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran's male reproductive organ condition(s) (brief summary):

b. Does the Veteran's treatment plan include taking continuous medication for the diagnosed condition?  
 Yes  No

List medications:

c. 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:

**Figure 8: Print Example: DBQ – Male Reproductive System Conditions– 2. Medical history**

2. Medical history

-----

a. Describe the history (including onset and course) of the Veteran's male reproductive organ condition(s) (brief summary):

b. Does the Veteran's treatment plan include taking continuous medication for the diagnosed condition?  
[X] Yes [ ] No

List medications:

c. Has the Veteran had an orchiectomy?  
[X] Yes [ ] No

Indicate testicle removed:  
[ ] Right [ ] Left [ ] Both

Indicate reason for removal:  
[ ] Undescended  
[ ] Congenitally underdeveloped  
[X] Other: provide reason for removal:

**2.4 Section 3. Voiding dysfunction**

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

**Table 4: Rules: DBQ – Male Reproductive System Conditions – 3. Voiding dysfunction**

Field/Question	Field Disposition	Valid Values	Format	Error Message
<b>3.Voiding dysfunction</b>	Enabled; Read Only	N/A	N/A	N/A
Does the Veteran have a voiding dysfunction?	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled; Mandatory.  Else; Optional  Choose one valid value	[Yes; No]	N/A	Please answer the question: Does the Veteran have a voiding dysfunction?
If yes, provide etiology of voiding dysfunction:	<i>Does the Veteran have a voiding dysfunction? = Yes</i> ; Enabled; Mandatory  Else; Disabled	N/A	Free Text	Please provide the etiology of the voiding dysfunction.
If the Veteran has a voiding dysfunction, complete the following questions:	If <i>Does the Veteran have a voiding dysfunction? = Yes</i> ; Enabled; Read-Only  Else; Disabled	N/A	N/A	N/A
a. Does the voiding dysfunction cause urine leakage?	If <i>Does the Veteran have a voiding dysfunction? = Yes</i> ; Enabled; Mandatory; Choose one valid value.  Else; Disabled	[Yes; No]	N/A	Please provide an answer to the question: Does the voiding dysfunction cause urine leakage?
Indicate severity (check one):	If <i>Does the voiding dysfunction cause urine leakage? = Yes</i> ; Enabled; Mandatory; Choose one valid value.  Else; Disabled	[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; Other, describe:]	N/A	Please check the applicable statement pertaining to the voiding dysfunction causing urine leakage.
Other, describe:	If <i>Severity = Other</i> , Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the other voiding dysfunction which causes urine leakage.
b. Does the voiding dysfunction require the use of an appliance?	If <i>Does the Veteran have a voiding dysfunction? = Yes</i> ; Enabled; Mandatory; Choose one valid	[Yes; No]	N/A	Please provide an answer to the question: Does the voiding dysfunction require the use of an appliance?

	value. Else; Disabled			
If yes, describe the appliance:	If <i>Does the voiding dysfunction require the use of an appliance?</i> = Yes; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the appliance used for the voiding dysfunction.
c. Does the voiding dysfunction cause increased urinary frequency?	If <i>Does the Veteran have a voiding dysfunction?</i> = Yes; Enabled; Mandatory; Choose one valid value.  Else; Disabled	[Yes; No]	N/A	Please provide an answer to the question: Does the voiding dysfunction cause increased urinary frequency?
If yes, check all that apply:	If <i>Does the voiding dysfunction cause increased urinary frequency?</i> = Yes; Enabled; Mandatory; Choose one valid value for Daytime and one valid value for Nighttime.  Else; Disabled	[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]	N/A	Please check the applicable statement(s) pertaining to the voiding dysfunction causing signs and/or symptoms of urinary frequency.
d. Does the voiding dysfunction cause signs or symptoms of obstructed voiding?	If <i>Does the Veteran have a voiding dysfunction?</i> = Yes; Enabled; Mandatory; Choose one valid value.  Else; Disabled	[Yes; No]	N/A	Please provide an answer to the question: Does the voiding dysfunction cause signs or symptoms of obstructed voiding?
If yes, check all that apply:	If <i>Does the voiding dysfunction cause signs or symptoms of obstructed voiding?</i> = Yes; Enabled; Mandatory; Choose one or more valid values.  Else; Disabled	[Hesitancy; slow or weak stream; decreased force of stream; 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; urinary retention requiring intermittent catheterization; urinary retention requiring continuous catheterization; Other, describe:]	N/A	Please check one or more boxes to indicate the signs and symptoms of obstructed voiding.

If checked, is hesitancy marked?	If <i>Voiding dysfunction signs or symptoms include Hesitancy</i> ; Enabled, Mandatory; Choose one valid value  Else; Disabled	[Yes; No]	N/A	Please indicate whether or not hesitancy is marked.
If checked, is stream markedly slow or weak?	If <i>Voiding dysfunction signs or symptoms include Slow or weak stream</i> ; Enabled, Mandatory; Choose one valid value  Else; Disabled	[Yes; No]	N/A	Please indicate whether or not stream is markedly slow or weak.
If checked, is force of stream markedly decreased?	If <i>Voiding dysfunction signs or symptoms include Decreased force of stream</i> ; Enabled, Mandatory; Choose one valid value.  Else; Disabled	[Yes; No]	N/A	Please indicate whether or not force of stream is markedly decreased.
Other, describe:	If <i>Voiding dysfunction signs or symptoms include Other</i> ; Enabled; Mandatory  Else Disabled	N/A	Free Text	Please describe the other signs and symptoms of obstructed voiding.

**Figure 9: Template Example: DBQ – Male Reproductive System Conditions – 3. Voiding dysfunction**

**3. Voiding dysfunction**

Does the Veteran have a voiding dysfunction?  
 Yes  No

If yes, provide etiology of voiding dysfunction: \_\_\_\_\_

If the Veteran has a voiding dysfunction, complete the following questions:

a. 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: \_\_\_\_\_

b. Does the voiding dysfunction require the use of an appliance?  
 Yes  No

If yes, describe the appliance: \_\_\_\_\_

c. 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

d. 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 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
- Urinary retention requiring intermittent catheterization
- Urinary retention requiring continuous catheterization
- Other, describe: \_\_\_\_\_

**Figure 10: Print Example: DBQ – Male Reproductive System Conditions – 3. Voiding dysfunction**

3. Voiding dysfunction  
-----  
Does the Veteran have a voiding dysfunction?  
 Yes     No

        If yes, provide etiology of voiding dysfunction:

If the Veteran has a voiding dysfunction, complete the following questions:

a. 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:

b. Does the voiding dysfunction require the use of an appliance?  
 Yes     No

        If yes, describe the appliance:

c. 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

d. 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 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  
 Urinary retention requiring intermittent catheterization  
 Urinary retention requiring continuous catheterization

Other, describe:

**2.5 Section 4. Urinary tract/kidney infection**

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

**Table 5: Rules: DBQ – Male Reproductive System Conditions – 4. Urinary tract/kidney infection**

Field/Question	Field Disposition	Valid Values	Format	Error Message
<b>4. Urinary tract/kidney infection</b>	Enabled, Read-Only	N/A	N/A	N/A
Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory, Choose one valid value.  Else, Enabled, Optional	[Yes; No]	N/A	Please answer the question: Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?
If Yes, provide etiology:	If <i>Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections? = Yes</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please provide the etiology of the recurrent symptomatic urinary tract or kidney infections.
If the Veteran has had recurrent symptomatic urinary tract or kidney infections, indicate all treatment modalities that apply:	If <i>Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections? = Yes</i> ; Enabled, Mandatory, Choose one or more valid values.  Else; Disabled	[No treatment; OR Long-term drug therapy; Hospitalization; Drainage; Continuous intensive management; Intermittent intensive management; Other, describe:]	N/A	Please check one or more boxes to indicate applicable treatment modalities for recurrent symptomatic urinary tract or kidney infections.
If checked, list medications used and indicate dates for courses of treatment over the past 12 months:	If <i>treatment modalities include long-term drug therapy</i> ; Enabled; Mandatory  Else; Disabled	N/A	Free Text	Please list medications used for urinary tract or kidney infections and their treatment dates.
If checked, indicate frequency of hospitalization:	If <i>treatment modalities include hospitalization</i> ; Enabled, Mandatory, Choose one valid value  Else; Disabled	[1 or 2 per year; >2 per year]	N/A	Please indicate the frequency of hospitalization.
If checked, indicate dates when drainage performed over past 12 months:	If <i>treatment modalities include drainage</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please indicate the dates that drainage was performed over the past 12 months.

<b>Field/Question</b>	<b>Field Disposition</b>	<b>Valid Values</b>	<b>Format</b>	<b>Error Message</b>
If checked, indicate types of treatment and medications used over past 12 months:	If <i>treatment modalities include continuous intensive management</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the types of treatment and medications for continuous intensive management used over the past 12 months.
If checked, indicate types of treatment and medications used over past 12 months:	If <i>treatment modalities include intermittent intensive management</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the types of treatment and medications for intermittent intensive management used over the past 12 months.
Other, describe:	If <i>treatment modalities include other</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe other treatment modalities used for urinary tract or kidney infections.

**Figure 11: Template Example: DBQ – Male Reproductive System Conditions – 4. Urinary tract/kidney infection**

**4. Urinary tract/kidney infection**

Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?  
 Yes  No

If yes, provide etiology: \_\_\_\_\_

If the Veteran has had recurrent symptomatic urinary tract or kidney infections, indicate all treatment modalities that apply:

No treatment  
 Long-term drug therapy  
 If checked, list medications used and indicate dates 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: \_\_\_\_\_

**Figure 12: Print Example: DBQ – Male Reproductive System Conditions – 4. Urinary tract/kidney infection**

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4. Urinary tract/kidney infection
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Does the Veteran have a history of recurrent symptomatic urinary tract or
kidney infections?
  [ ] Yes   [X] No

    If yes, provide etiology:

    If the Veteran has had recurrent symptomatic urinary tract or kidney
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:

## 2.6 Section 5. Erectile dysfunction

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

**Table 6: Rules: DBQ – Male Reproductive System Conditions – 5. Erectile Dysfunction**

Field/Question	Field Disposition	Valid Values	Format	Error Message
<b>5. Erectile dysfunction</b>	Enabled; Read-Only	N/A	N/A	N/A
a. Does the Veteran have erectile dysfunction?	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory  Else, Enabled, Optional  Choose one valid value.	[Yes; No]	N/A	Please provide an answer to the question: Does the Veteran have erectile dysfunction?
If yes, provide etiology:	If <i>Does the Veteran have erectile dysfunction? = Yes</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please provide the etiology of erectile dysfunction.
b. If the Veteran has erectile dysfunction, is it as likely as not (at least 50% probability) attributable to one of the diagnoses in Section 1, including residuals of treatment for this diagnosis?	If <i>Does the Veteran have erectile dysfunction? = Yes</i> ; Enabled, Mandatory, Choose one valid value.  Else; Disabled	[Yes; No]	N/A	Please answer whether or not erectile dysfunction is attributable to one of the diagnoses in Section 1, including its residuals of treatment.
If yes, specify the diagnosis to which the erectile dysfunction is as likely as not attributable:	If <i>previous question = Yes</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please specify the diagnosis to which erectile dysfunction is as likely as not attributable.
c. If the Veteran has erectile dysfunction, is he able to achieve an erection sufficient for penetration and ejaculation (without medication)?	If <i>Does the Veteran have erectile dysfunction? = Yes</i> ; Enabled, Mandatory; Choose one valid value.  Else; Disabled	[Yes; No]	N/A	Please answer whether or not the Veteran is able to achieve an erection sufficient for penetration and ejaculation (without medication).
If no, is the Veteran able to achieve an erection sufficient for penetration and ejaculation (with medication)?	If <i>previous question = No</i> ; Enabled, Mandatory; Choose one valid value.  Else; Disabled	[Yes; No]	N/A	Please answer whether or not the Veteran is able to achieve an erection sufficient for penetration and ejaculation (with medication).

**Figure 13: Template Example: DBQ – Male Reproductive System Conditions –5. Erectile dysfunction**

**5. Erectile dysfunction**

a. Does the Veteran have erectile dysfunction?  
 Yes  No

If yes, provide etiology:

b. 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 1, 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:

c. If the Veteran has erectile dysfunction, is he able to achieve an erection sufficient for penetration and ejaculation (without medication)?  
 Yes  No

If no, is the Veteran able to achieve an erection sufficient for penetration and ejaculation (with medication)?  
 Yes  No

**Figure 14: Print Example: DBQ – Male Reproductive System Conditions – 5. Erectile dysfunction**

5. Erectile dysfunction  
-----

a. Does the Veteran have erectile dysfunction?  
[ ] Yes [ ] No

If yes, provide etiology:

b. 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 1, 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:

c. If the Veteran has erectile dysfunction, is he able to achieve an erection sufficient for penetration and ejaculation (without medication)?  
[ ] Yes [ ] No

If no, is the Veteran able to achieve an erection sufficient for penetration and ejaculation (with medication)?  
[ ] Yes [ ] No

**2.7 Section 6. Retrograde ejaculation**

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

**Table 7: Rules: DBQ – Male Reproductive System Conditions – 6. Retrograde ejaculation**

Field/Question	Field Disposition	Valid Values	Format	Error Message
<b>6. Retrograde ejaculation</b>	Enabled; Read-Only	N/A	N/A	N/A
a. Does the Veteran have retrograde ejaculation?	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory  Else, Enabled, Optional  Choose one valid value	[Yes; No]	Free Text	Please provide an answer to the question: Doe the Veteran have retrograde ejaculation?
If yes, provide etiology of the retrograde ejaculation:	If <i>Does the Veteran have retrograde ejaculation? = Yes</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please provide the etiology of retrograde ejaculation.
b. 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 1, including residuals of treatment for this diagnosis?	If <i>Does the Veteran have retrograde ejaculation? = Yes</i> ; Enabled, Mandatory; Choose one valid value.  Else; Disabled	[Yes; No]	N/A	Please answer whether or not retrograde ejaculation is attributable to one of the diagnoses in Section 1, including its residuals of treatment.
If yes, specify the diagnosis to which the retrograde ejaculation is as likely as not attributable:	If <i>previous question = Yes</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please specify the diagnosis to which retrograde ejaculation is as likely as not attributable.

**Figure 15: Template Example: DBQ – Male Reproductive System Conditions –6. Retrograde ejaculation**

**6. Retrograde ejaculation**

a. Does the Veteran have retrograde ejaculation?  
 Yes  No

If yes, provide etiology of retrograde ejaculation: \_\_\_\_\_

b. 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 1, 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: \_\_\_\_\_

**Figure 16: Print Example: DBQ – Male Reproductive System Conditions – 6. Retrograde ejaculation**

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6. Retrograde ejaculation
-----
a. Does the Veteran have retrograde ejaculation?
  [ ] Yes   [ ] No

      If yes, provide etiology of the retrograde ejaculation:
  
```

b. 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 1, 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:

## 2.8 Section 7. Male reproductive organ infections

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

**Table 8: Rules: DBQ – Male Reproductive System Conditions – 7. Male reproductive organ infections**

Field/Question	Field Disposition	Valid Values	Format	Error Message
<b>7. Male reproductive organ infections</b>	Enabled; Read-Only	N/A	N/A	N/A
b. Does the Veteran have a history of chronic epididymitis, epididymo-orchitis or prostatitis?	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory  Else, Enabled, Optional  Choose one valid value	[Yes; No]	N/A	Please provide an answer to the question: Does the Veteran have a history of chronic epididymitis, epididymo-orchitis or prostatitis?
If yes, indicate all treatment modalities that apply:	If <i>Does the Veteran have a history of chronic epididymitis, epididymo-orchitis or prostatitis? = Yes</i> , Enabled, Mandatory; Choose one or more valid values.  Else disabled	[No treatment; OR Long-term drug therapy; Hospitalization; Continuous intensive management; Intermittent intensive management; Other, describe:]	N/A	Please check one or more boxes to indicate applicable treatment modalities for chronic epididymitis.
If checked, list medications used and indicate dates for courses of treatment over the past 12 months:	If <i>treatment modalities include Long-term drug therapy</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please list medications used for chronic epididymitis, epididymo-orchitis or prostatitis, and their treatment dates.
If checked, indicate frequency of hospitalization:	If <i>treatment modalities include hospitalization</i> ; Enabled, Mandatory; Choose one valid value  Else; Disabled	[1 or 2 per year; > 2 per year]	N/A	Please indicate the frequency of hospitalization.
If checked, indicate types of treatment and medications used over the past 12 months:	If <i>treatment modalities include continuous intensive management</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the types of treatment and medications for continuous intensive management used over the past 12 months.
If checked, indicate types of treatment and medications used over the past 12 months:	If <i>treatment modalities include intermittent intensive management</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the types of treatment and medications for intermittent intensive management used over the past 12 months.

Other, describe:	If <i>treatment modalities include other</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the other treatment modalities used for chronic epididymitis, epididymo-orchitis or prostatitis.
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**Figure 17: Template Example: DBQ – Male Reproductive System Conditions –7. Male reproductive organ infections**

**7. Male reproductive organ infections**

Does the Veteran have a history of chronic epididymitis, epididymo-orchitis or prostatitis?  
 Yes  No

If yes, indicate all treatment modalities that apply:

No treatment  
 Intensive management  
 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  
 Continuous  
 If checked, indicate types of treatment and medications used over past 12 months:

Intermittent  
 If checked, indicate types of treatment and medications used over past 12 months:

Other, describe:

**Figure 18: Print Example: DBQ – Male Reproductive System Conditions – 7. Male reproductive organ infections**

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7. Male reproductive organ infections
-----
Does the Veteran have a history of chronic epididymitis, epididymo-orchitis
or prostatitis?
[ ] Yes [ ] No

If yes, 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
[ ] 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:

## 2.9 Section 8. Physical exam

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

**Table 9: Rules: DBQ – Male Reproductive System Conditions – 8. Physical exam**

Field/Question	Field Disposition	Valid Values	Format	Error Message
<b>8. Physical exam</b>	Enabled; Read-Only	N/A	N/A	N/A
a. Penis	If <i>Diagnosis = Yes</i> and at least one diagnosis selected in the <i>Diagnosis</i> section; Enabled, Mandatory  Else; Enabled, Optional  Choose one valid value	[Normal; Not examined per Veteran’s request; Not examined, penis exam not relevant to condition; Abnormal]	N/A	Please select a value from the penis exam group.
If abnormal, indicate severity:	If <i>Penis exam = Abnormal</i> , Enabled, Mandatory, Choose one valid value.  Else; Disabled	[Loss/removal of half or more of penis; Loss/removal of glans penis; Penis deformity (such as Peyronie’s disease)]	N/A	Please indicate the severity of the penis abnormality.
If checked, describe:	If <i>Penis exam = Penis deformity (such as Peyronie’s disease)</i> , Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe penis deformity.
b. Testes	If <i>Diagnosis = Yes</i> and at least one diagnosis selected in the <i>Diagnosis</i> section;; Enabled, Mandatory  Else; Enabled, Optional  Choose one valid value.	[Normal; Not examined per Veteran’s request; Not examined, testicular exam not relevant to condition; Abnormal]	N/A	Please select a value from the testes exam group.
If abnormal, check all that apply: Right testicle:	If <i>Testicular exam = Abnormal AND no abnormality selected for either right or left testicle</i> ; Enabled, Mandatory, Choose one or more valid values.  Else; Disabled	[Size 1/3 or less of normal; Size ½ to 1/3 of normal; Considerably harder than normal; Considerably softer than normal; Absent; Other abnormality]	N/A	Please indicate the testes abnormality.
Describe:	If <i>Right testicular exam includes Other abnormality</i> ; Enabled, Mandatory	N/A	Free Text	Please describe the other abnormality of the right testicle.

	Else; Disabled			
Left:	If <i>Testicular exam = Abnormal AND no abnormality selected for either right or left testicle</i> ; Enabled, Mandatory, Choose one or more valid values.  Else; Disabled	[Size 1/3 or less of normal; Size ½ to 1/3 of normal; Considerably harder than normal; Considerably softer than normal; Absent; Other abnormality]	N/A	Please indicate the testes abnormality.
Describe:	If <i>Left testicular exam includes Other abnormality</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the other abnormality of the left testicle.
c. Epididymis	If <i>Diagnosis = Yes and at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory  Else; Enabled, Optional  Choose one valid value.	[Normal; Not examined per Veteran's request; Not examined, epididymis exam not relevant to condition; Abnormal]	N/A	Please select a value from the epididymis exam group.
If abnormal, check all that apply: Right epididymis:	If <i>Epididymis exam = Abnormal AND no abnormality selected for either right or left epididymis</i> ; Enabled, Mandatory; Choose one valid value.  Else; Disabled	[Tender to palpation; Other, describe]	N/A	Please indicate the epididymis abnormality.
Other, describe:	If <i>Epididymis exam includes other</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the other abnormality of the right epididymis.
Left epididymis:	If <i>Epididymis exam = Abnormal AND no abnormality selected for either right or left epididymis</i> ; Enabled, Mandatory; Choose one valid value  Else; Disabled	[Tender to palpation; Other, describe]	N/A	Please indicate the epididymis abnormality.
Other, describe:	If <i>Epididymis exam includes other</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the other abnormality of the left epididymis.
d. Prostate	If <i>Diagnosis = Yes and at least one diagnosis selected in</i>	[Normal; Not examined per	N/A	Please select a value from the

	<i>the Diagnosis section;</i> Enabled, Mandatory  Else; Enabled, Optional  Choose one valid value	Veteran's request; Not examined, prostate exam not relevant to condition; Abnormal]		prostate exam group.
If abnormal, describe:	If <i>Prostate exam = abnormal;</i> Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the abnormality of the prostate.

**Figure 19: Template Example: DBQ – Male Reproductive System Conditions –8. Physical exam**

**8. Physical exam**

a. Penis

Normal  
 Not examined per Veteran's request  
 Not examined; penis exam not relevant to condition  
 Abnormal

If abnormal, indicate severity:

Loss/removal of half or more of penis  
 Loss/removal of glans penis  
 Penis deformity (such as Peyronie's disease)

If checked, describe:

b. Testes

Normal  
 Not examined per Veteran's request  
 Not examined; testicular exam not relevant to condition  
 Abnormal

If abnormal, check all that apply:

Right testicle

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

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:

c. Epididymis

Normal  
 Not examined per Veteran's request  
 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: \_\_\_\_\_

d. Prostate

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

If abnormal, describe: \_\_\_\_\_

**Figure 20: Print Example: DBQ – Male Reproductive System Conditions – 8. Physical exam**

```

8.Physical exam
-----
a. Penis
  [ ] Normal
  [ ] Not examined per Veteran's request
  [ ] Not examined; penis exam not relevant to condition
  [ ] Abnormal

      If abnormal, indicate severity:
        [ ] Loss/removal of half or more of penis
        [ ] Loss/removal of glans penis
        [ ] Penis deformity (such as Peyronie's disease)
          If checked, describe:

b. Testes
  [ ] Normal
  [ ] Not examined per Veteran's request
  [ ] Not examined; testicular exam not relevant to condition
  [ ] Abnormal

      If abnormal, check all that apply:
        Right testicle
          [ ] 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
          [ ] 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:

c. Epididymis

Normal  
 Not examined per Veteran's request  
 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:

d. Prostate

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

If abnormal, describe:

## 2.10 Section 9. Tumors and Neoplasms

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

**Table 10: Rules: DBQ – Male Reproductive System Conditions – 9. Tumors and Neoplasms**

Field/Question	Field Disposition	Valid Values	Format	Error Message
<b>9. Tumors and Neoplasms</b>	Enabled, Read-Only	N/A	N/A	N/A
a. Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory  Else; Enabled, Optional  Choose one valid value.	[Yes; No]	N/A	Please provide an answer to the question: Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?
If yes, complete the following:	If <i>Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?? = Yes</i> ; Enabled, Read-Only  Else; Disabled	N/A	N/A	N/A
b. Is the neoplasm	If <i>Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section? = Yes</i> ; Enabled; Mandatory, Choose one valid value.  Else; Disabled	[Benign; Malignant]	N/A	Please indicate whether the neoplasm is benign or malignant.
c. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?	If <i>Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section? = Yes</i> ; Enabled; Mandatory, Choose one valid value.  Else; Disabled	[Yes; No, watchful waiting]	N/A	Please provide an answer to the question: Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?
If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):	If <i>Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases? = Yes</i> ; Enabled, Mandatory, Choose one or more valid values.	[Treatment completed, currently in watchful waiting status; OR Surgery; Radiation therapy;	N/A	Please indicate all applicable treatment types for a benign or malignant neoplasm or metastases that the Veteran either is

	Else; Disabled	Antineoplastic chemotherapy; Other therapeutic procedure; Other therapeutic treatment]		currently undergoing or has completed.
If checked, describe:	If treatments include <i>Surgery</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the surgery.
Date(s) of surgery:	If treatments include <i>Surgery</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please enter the date(s) of surgery.
Date of most recent treatment:	If treatments include <i>Radiation therapy</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please enter the date of the most recent radiation therapy treatment.
Date of completion of treatment or anticipated date of completion:	If treatments include <i>Radiation therapy</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please enter the date (actual or anticipated) of completion of the radiation therapy treatment,
Date of most recent treatment:	If treatments include <i>Antineoplastic chemotherapy</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please enter the date of the most recent antineoplastic chemotherapy treatment.
Date of completion of treatment or anticipated date of completion:	If treatments include <i>Antineoplastic chemotherapy</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please enter the date (actual or anticipated) of completion of the antineoplastic chemotherapy treatment.
If checked, describe procedure:	If treatments include <i>Other therapeutic procedure</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the other therapeutic procedure.
Date of most recent procedure:	If treatments include <i>Other therapeutic procedure</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please enter the date of the most recent other therapeutic procedure.
If checked, describe treatment:	If treatments include <i>Other therapeutic treatment</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the other therapeutic treatment.

Date of completion of treatment or anticipated date of completion:	If treatments include <i>Other therapeutic treatment</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please enter the date (actual or anticipated) of completion of the other therapeutic treatment.
d. 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?	If <i>Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?</i> = Yes; Enabled; Mandatory, Choose one valid value  Else; Disabled	[Yes; No]		Please indicate whether or not the Veteran has any residual conditions or complications due to the neoplasm (including metastases) or its treatment, other than those already documented.
If yes, list residual conditions and complications (brief summary):	If <i>previous question</i> = Yes; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please list the residual conditions and complications due to the neoplasm (including metastases) or its treatment.
e. 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:	If <i>Does the Veteran have a benign or malignant neoplasm or metastases related to any of the diagnoses in the Diagnosis section?</i> = Yes; Enabled; Optional  Else; Disabled	N/A	Free Text	N/A

**Figure 21: Template Example: DBQ – Male Reproductive System Conditions – 9. Tumors and Neoplasms**

**9. Tumors and neoplasms**

a. 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, complete the following:

b. Is the neoplasm  
 Benign  Malignant

c. 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: \_\_\_\_\_

d. 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): \_\_\_\_\_

e. 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:  
 \_\_\_\_\_

**Figure 22: Print Example: DBQ – Male Reproductive System Conditions – 9. Tumors and Neoplasms**

9. Tumors and neoplasms  
 -----  
 a. 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, complete the following:

b. Is the neoplasm

Benign     Malignant

c. 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:

d. 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):

e. 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:

## 2.11 Section 10. Other pertinent physical findings, complications, conditions, signs and/or symptoms

All questions in this section may be answered as described by the rules below. If all mandatory questions are not answered, the error message(s) will appear in a popup window as depicted below.

**Table 11: Rules: DBQ – Male Reproductive System Conditions – 10. Other pertinent physical findings, complications, conditions, signs and/or symptoms**

Field/Question	Field Disposition	Valid Values	Format	Error Message
<b><u>10. Other pertinent physical findings, complications, conditions, signs and/or symptoms</u></b>	Enabled, Read-Only	N/A	N/A	N/A
a. 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?	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory  Else; Enabled, Optional  Choose one valid value	[Yes; No]	N/A	Please indicate whether or not the Veteran has any scars (surgical or otherwise) related to any conditions (or their treatment) listed in the Diagnosis section.
If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?	If <i>previous question = Yes</i> ; Enabled, Mandatory, Choose one valid value  Else; Disabled	[Yes; No]	N/A	Please answer whether or not any of the scars are painful and/or unstable, or if the total area of all related scars is greater than 39 square cm (6 square inches).
If yes, also complete a Scars Questionnaire.	If <i>previous question = Yes</i> ; Enabled, Read-Only  Else; Disabled	N/A	N/A	N/A
b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory  Else; Enabled, Optional  Choose one valid value	[Yes; No]	N/A	Please provide an answer to the question: Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?
If yes, describe (brief summary):	If <i>Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms? = Yes</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe any other pertinent physical findings, complications, conditions, signs or symptoms.

**Figure 23: Template Example: DBQ – Male Reproductive System Conditions – 10. Other pertinent physical findings, complications, conditions, signs and/or symptoms**

**10. Other pertinent physical findings, complications, conditions, signs and/or symptoms**

a. 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 the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?

Yes  No

If yes, describe:

**Figure 24: Print Example: DBQ – Male Reproductive System Conditions – 10. Other pertinent physical findings, complications, conditions, signs and/or symptoms**

10. Other pertinent physical findings, complications, conditions, signs and/or symptoms

-----

a. 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 the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

[ ] Yes [ ] No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?

[ ] Yes [ ] No

If yes, describe:

**2.12 Section 11. Diagnostic testing**

All questions in this section may be answered as described by the rules below.

**Table 12: Rules: DBQ – Male Reproductive System Conditions – 11. Diagnostic testing**

Field/Question	Field Disposition	Valid Values	Format	Error Message
<b>11. Diagnostic testing</b>	Enabled; Read-Only	N/A	N/A	N/A
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.	Enabled; Read-Only	N/A	N/A	N/A
a. Has the Veteran had a testicular biopsy to determine the presence of spermatozoa?	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory  Else; Enabled, Optional  Choose one valid value.	[Yes; No]	N/A	Please provide an answer to the question: Has the Veteran had a testicular biopsy to determine the presence of spermatozoa?
If yes, were spermatozoa present?	If <i>Has the Veteran had a testicular biopsy to determine the presence of spermatozoa = Yes</i> ; Enabled, Mandatory, Choose one valid value.  Else; Disabled	[Yes; No]	N/A	Please answer whether or not spermatozoa were present in the testicular biopsy.
Date of biopsy:	If <i>Has the Veteran had a testicular biopsy to determine the presence of spermatozoa = Yes</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please enter the date of the testicular biopsy.
b. Have any other imaging studies, diagnostic procedures or laboratory testing been performed and are the results available?	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory  Else; Enabled, Optional  Choose one valid value.	[Yes; No]	N/A	Please provide an answer to the question: Have any other imaging studies, diagnostic procedures or laboratory testing been performed and are the results available?
If yes, provide type of test or procedure, date and results (brief summary):	If <i>Have any other imaging studies, diagnostic procedures or laboratory testing been performed and are the results available? = Yes</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please provide the type of test or procedure, its date and the results.

**Figure 25: Template Example: DBQ – Male Reproductive System Conditions – 11. Diagnostic testing**

**11. 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.

a. Has the Veteran had a testicular biopsy to determine the presence of spermatozoa?  
 Yes  No

If yes, were spermatozoa present?  
 Yes  No

Date of biopsy:

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):

**Figure 26: Print Example: DBQ – Male Reproductive System Conditions– 11. Diagnostic testing**

11. 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.

a. Has the Veteran had a testicular biopsy to determine the presence of spermatozoa?  
[ ] Yes [ ] No

If yes, were spermatozoa present?  
[ ] Yes [ ] No

Date of biopsy:

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):

**2.13 Section 12. Functional impact**

All questions in this section may be answered as described by the rules below.

**Table 13: Rules: DBQ – Male Reproductive System Conditions – 12. Functional impact**

Field/Question	Field Disposition	Valid Values	Format	Error Message
<b>12. Functional impact</b>	Enabled; Read-Only	N/A	N/A	N/A
Does the Veteran's male reproductive system condition(s), including neoplasms, if any, impact his ability to work?	If <i>Diagnosis = Yes</i> and <i>at least one diagnosis selected in the Diagnosis section</i> ; Enabled, Mandatory  Else; Enabled, Optional  Choose one valid value	[Yes; No]	N/A	Please answer the question: Does the Veteran's male reproductive system condition(s), including neoplasms, if any, impact his ability to work?
If yes, describe the impact of each of the Veteran's male reproductive system condition(s), providing one or more examples:	If <i>Does the Veteran's male reproductive system condition(s), including neoplasms, if any, impact his ability to work? = Yes</i> ; Enabled, Mandatory  Else; Disabled	N/A	Free Text	Please describe the impact of each of the Veteran's male reproductive system conditions on his ability to work, providing one or more examples.

**Figure 27: Template Example: DBQ – Male Reproductive System Conditions – 12. Functional impact**

**12. Functional impact**  
 Does the Veteran's male reproductive system condition(s), including neoplasms, if any, impact his ability to work?  
 Yes  No  
 If yes, describe the impact of each of the Veteran's male reproductive system condition(s), providing one or more examples:  
 \_\_\_\_\_

**Figure 28: Print Example: DBQ – Male Reproductive System Conditions – 12. Functional impact**

```

12. Functional impact
-----
Does the Veteran's male reproductive system condition(s), including
neoplasms, if any, impact his ability to work?
  [ ] Yes   [ ] No

      If yes, describe the impact of each of the Veteran's male
      reproductive system condition(s), providing one or more examples:
  
```

2.14 Section 13. Remarks, if any

All questions in this section may be answered as described by the rules below.

**Table 14: Rules: DBQ – Male Reproductive System Conditions –13. Remarks, if any**

Field/Question	Field Disposition	Valid Values	Format	Error Message
<b>13. Remarks, if any:</b>	Enabled, Optional	N/A	Free Text	N/A

**Figure 29: Template Example: DBQ – Male Reproductive System Conditions – 13. Remarks, if any**

**13. Remarks, if any**

**Figure 30: Print Example: DBQ – Male Reproductive System Conditions – 13. Remarks, if any**

13. Remarks, if any:  
-----

### 3 Male Reproductive System Conditions DBQ-AMIE Worksheet

The DBQ-AMIE worksheets are accessed via the Print Blank C&P Worksheet menu [DVBA C PRINT BLANK C&P WORKSHE] option. Select the "DBQ MALE REPRODUCTIVE SYSTEM CONDITIONS" worksheet. DBQ-AMIE worksheets should be sent to a printer.

Male Reproductive System Conditions  
Disability Benefits Questionnaire

Name of patient/Veteran: \_\_\_\_\_ SSN: \_\_\_\_\_

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.

1. Diagnosis:

Does the Veteran now have or has he ever been diagnosed with any conditions of the male reproductive system?

Yes  No

If no, provide rationale (e.g., Veteran has never had any known male reproductive organ conditions): \_\_\_\_\_

If yes, 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 injury ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Prostate hypertrophy (BPH) ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Prostatitis, chronic ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Prostate surgical residuals (as addressed in items 3-6) 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 male reproductive system.) ICD Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Other diagnosis #1: \_\_\_\_\_

ICD code: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

Page: 2

Disability Benefits Questionnaire for  
Male Reproductive System Conditions

Other diagnosis #2: \_\_\_\_\_

ICD code: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

If there are additional diagnoses that pertain to the male reproductive organ conditions, list using above format: \_\_\_\_\_

2. Medical history

a. Describe the history (including onset and course) of the Veteran's male reproductive organ condition(s) (brief summary): \_\_\_\_\_

b. Does the Veteran's treatment plan include taking continuous medication for the diagnosed condition?

Yes  No List medications: \_\_\_\_\_

c. 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: \_\_\_\_\_

3. Voiding dysfunction

Does the Veteran have a voiding dysfunction?

Yes  No

If yes, provide etiology of voiding dysfunction: \_\_\_\_\_

If the Veteran has a voiding dysfunction, complete the following questions:

a. 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: \_\_\_\_\_

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b. Does the voiding dysfunction require the use of an appliance?

Yes  No

If yes, describe the appliance: \_\_\_\_\_

c. 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

d. 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 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
- Urinary retention requiring intermittent catheterization
- Urinary retention requiring continuous catheterization
- Other, describe: \_\_\_\_\_

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#### 4. Urinary tract/kidney infection

Does the Veteran have a history of recurrent symptomatic urinary tract or kidney infections?

Yes  No

If yes, provide etiology: \_\_\_\_\_

If the Veteran has had recurrent symptomatic urinary tract or kidney 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: \_\_\_\_\_

5. Erectile dysfunction

a. Does the Veteran have erectile dysfunction?

Yes  No

If yes, provide etiology: \_\_\_\_\_

b. 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 1, 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: \_\_\_\_\_

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c. If the Veteran has erectile dysfunction, is he able to achieve an erection sufficient for penetration and ejaculation (without medication)?

Yes  No

If no, is the Veteran able to achieve an erection sufficient for penetration and ejaculation (with medication)?

Yes  No

6. Retrograde ejaculation

a. Does the Veteran have retrograde ejaculation?

Yes  No

If yes, provide etiology of the retrograde ejaculation: \_\_\_\_\_

b. 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 1, 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: \_\_\_\_\_

7. Male reproductive organ infections

Does the Veteran have a history of chronic epididymitis, epididymo-orchitis or prostatitis?

Yes  No

If yes, 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
- 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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8. Physical exam

a. Penis

- Normal
- Not examined per Veteran's request
- Not examined; penis exam not relevant to condition
- Abnormal  
If abnormal, indicate severity:
  - Loss/removal of half or more of penis
  - Loss/removal of glans penis
  - Penis deformity (such as Peyronie's disease)
  - If checked, describe: \_\_\_\_\_

b. Testes

- Normal
- Not examined per Veteran's request
- Not examined; testicular exam not relevant to condition
- Abnormal

If abnormal, check all that apply:

Right testicle

- 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

- 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: \_\_\_\_\_

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c. Epididymis

- Normal
- Not examined per Veteran's request
- 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: \_\_\_\_\_

d. Prostate

- Normal
- Not examined per Veteran's request
- Not examined; prostate exam not relevant to condition
- Abnormal
- If abnormal, describe: \_\_\_\_\_

9. Tumors and neoplasms

a. 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, complete the following:

b. Is the neoplasm

Benign  Malignant

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c. 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: \_\_\_\_\_

d. 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):

e. 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: \_\_\_\_\_

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10. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. 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 the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_

11. 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.

a. Has the Veteran had a testicular biopsy to determine the presence of spermatozoa?

Yes  No

If yes, were spermatozoa present?

Yes  No

Date of biopsy: \_\_\_\_\_

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):

\_\_\_\_\_

12. Functional impact

Does the Veteran's male reproductive system condition(s), including neoplasms, if any, impact his ability to work?

Yes  No

If yes, describe the impact of each of the Veteran's male reproductive system condition(s), providing one or more examples: \_\_\_\_\_

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13. Remarks, if any: \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician printed name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical license #: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician address: \_\_\_\_\_

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.