Veterans Affairs Canada | Anciens Combattants Canada

Protected information when completed.

File No.:	Decision No.:
	Service No(s).:

Medical Questionnaire: Urinary, Sexual, Reproductive Conditions

Family name:	Given name:	Date of Birth:
Name of Physician:		Date of Examination:

MEDICAL DIAGNOSIS(ES) OF CLAIMED/PENSIONED CONDITION(S) REQUIRING EXAMINATION:

1. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

2. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

3. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

Very specific information is required by Veterans Affairs Canada to evaluate and assess a client's claimed pensioned condition(s). As this information may not generally form part of the clinical history, please help us to collect this information by answering the following questions.

Please complete applicable sections only.

If additional recording space is required, please use the "additional comments" sheet.

MEDICAL HISTORY: Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors.

Injuries? ◯ Yes ◯ No **Describe (include dates)**

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No
If yes, indicate the nature of the test/consultation, and the appointment date (if known).

Physical Examination - Female:

Please indicate the presence of any of the following (please check all that apply) within the appropriate category(ies):

Ovaries: Comment:

- ☐ tenderness/pain, specify: ◯ mild ◯ moderate ◯ severe
- ☐ infertility at or after menopause
- ☐ pre-menopausal oophrectomy, specify: ◯ unilateral ◯ bilateral
- ☐ pre-menopausal salpingectomy
- ☐ other, specify: _____

Uterus: Comment:

- ☐ heavy irregular bleeding
- ☐ tenderness/pain, specify: ◯ mild ◯ moderate ◯ severe
- ☐ masses
- ☐ hysterectomy, specify: ◯ pre-menopausal ◯ post-menopausal
- ☐ endometriosis
- ☐ other, specify: _____

Family name:	Given name:	File No:

Cervix/Vagina:

Comment:

- ☐ vaginal fistulae
- ☐ other, specify: _____

Fallopian Tubes:

Comment:

- ☐ tubal ligation, elective
- ☐ loss of tubal patency, premenopausal

Breasts:

Comment:

- ☐ lumpectomy
- ☐ right mastectomy, specify: ◯ simple or ◯ radical
- ☐ left mastectomy, specify: ◯ simple or ◯ radical
- ☐ bilateral mastectomy, specify: ◯ simple or ◯ radical
- ☐ other, specify: _____

Physical Examination - Male:

Testicles:

Comment:

- ☐ decreased testicular mobility
- ☐ loss or atrophy of 1 testicle, specify: ◯ right or ◯ left
- ☐ bilateral loss or atrophy of the testicles
- ☐ permanent sterility
- ☐ other, specify: _____

Penis:

Comment:

- ☐ erectile dysfunction; responsive to treatment
- ☐ erectile dysfunction; unresponsive to treatment
- ☐ severe post ejaculatory pain; total avoidance of intercourse
- ☐ removal of the glans penis
- ☐ loss of penis proximal to the glans
- ☐ peyronie's disease; capable of intercourse
- ☐ peyronie's disease; incapable of intercourse

Scrotum:

Comment:

- ☐ varicocele, with daily pain? ◯ yes ◯ no
- ☐ hydrocele, with daily pain? ◯ yes ◯ no
- ☐ other, specify: _____ with daily pain? ◯ yes ◯ no

Prostate:

Comment:

- ☐ prostatitis
- ☐ benign prostatic hypertrophy
- ☐ epididymitis

Breasts:

Comment:

- ☐ lumpectomy
- ☐ gynecomastia
- ☐ persistent mammary discharge
- ☐ mastectomy, specify: ◯ unilateral, ◯ bilateral
- ☐ other, specify: _____

PLEASE ATTACH/FORWARD COPIES OF RELEVANT REPORTS (E.G. DIAGNOSTIC, CONSULTATION, OPERATIVE, LABORATORY, HOSPITAL DISCHARGE SUMMARIES)

Family name:	Given name:	File No.:

TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response), details of relevant surgery/hospitalization and other therapies (e.g. physiotherapy).

COMPLICATIONS:

Are there any complications resulting from the claimed/pensioned condition(s)? ◯ Yes ◯ No

If yes, please provide details:

PHYSICAL EXAMINATION: (fill out only portion applicable to the pensioned/claimed condition(s))

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Respiration _____

GENERAL APPEARANCE:

EXAMINATION FINDINGS: Describe any relevant examination findings.

OTHER PERTINENT FINDINGS: (i.e. other conditions that may be contributing to the client's impairment.)

Physician's Signature:	Is VAC to be invoiced? ◯ Yes ◯ No	Telephone No. ( )	Today's date:

Family name:	Given name:	File No.:

Additional Comments:

Physician's signature:	Today's date: