|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Australian Government Crest - Department of Veteran's Affairs branding | Female Reproductive System  Medical Impairment Assessment | | | | | | |
| Veteran | | | | |  | UIN | |
|  | | |  |  | | | |
|  | | | | | |  |  |
| Please assess the following conditions: | | | | | | | |

1. Please select the most accurate description of impairment of **fertility**.

| **Description** | **Select One** |
| --- | --- |
| None. |  |
| Infertility associated with natural menopause. |  |
| Difficulty conceiving but has conceived naturally. |  |
| Reduced fertility – successful pregnancy has been achieved only with medical intervention (e.g. IVF, hormonal stimuli). |  |
| Pregnancy is medically proscribed due to serious risk to the health of mother or potential child. |  |
| Complete infertility – unable to become pregnant or maintain a pregnancy to term. |  |

At what age was the onset of this level of infertility?

1. Please select **all** that apply in relation to the **cervix and / or uterus**.

| **Description** | **Select** |
| --- | --- |
| No abnormality. |  |
| Scarring or partial loss of the cervix without loss of function. |  |
| Cervical incompetence. |  |
| Endometriosis. |  |
| Severe menorrhagia. |  |
| Hysterectomy. |  |

At what age was the hysterectomy (if applicable)?

1. Please select the most accurate description in relation to the **ovaries and fallopian tubes**.

| **Description** | **Select One** |
| --- | --- |
| No abnormality. |  |
| Recurrent Salpingitis. |  |
| Loss or removal of single ovary. |  |
| Loss or removal of both ovaries (whether or not associated with hysterectomy). |  |

At what age did loss of ovaries occur (if applicable)?

1. Please select **all** that apply to any physical alteration(s) of the **vagina, and external genitalia**.

| **Description** | **Select** |
| --- | --- |
| No abnormality. |  |
| Minor scarring or anatomic variation. |  |
| Clitoridectomy. |  |
| Vulvectomy. |  |

At what age did this loss occur?

1. Please list **all conditions** contributing to the reported impairment and indicate the **percentage contribution**. Include any previously known condition(s) and any new condition(s) you have identified. The contribution total must equal 100%.

| **Condition** | **Contribution %** |
| --- | --- |
| e.g. Cervical Cancer | 25% |
|  |  |
|  |  |
|  |  |
| **Total** | **100%** |

|  |  |  |  |
| --- | --- | --- | --- |
| Doctor's signature | Doctor's name | Date | Time to complete form |
|  |  |  |  |