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| Australian Government crest, Department of Veterans' Affairs branding | Male Reproductive SystemMedical Impairment Assessment |
| Veteran |  | UIN |
|  |  |  |
|  |  |  |
| Please assess the following conditions:For this assessment, each condition needs to be assessed in **isolation** from all others. This means that when assessing a condition, you will need to assess the impairment **as though** **only that single condition is present**, and that the veteran is otherwise healthy and normal. |

1. Please select the most accurate description of the **treatment**, for each condition *in isolation.*

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| None. |[ ] [ ] [ ]
| **Intermittent** treatment. |[ ] [ ] [ ]
| **Frequent** treatment. |[ ] [ ] [ ]
| **Continuous** treatment. |[ ] [ ]  [ ]  |

1. Please select the most accurate description of any impairment of **sexual function**.

| **Description** | **Select One** |
| --- | --- |
| None. |[ ]
| **Difficulty with erection**, **ejaculation** and/or **sensation**. |[ ]
| **Complete loss of ejaculation and/or sensation**, but sufficient erection remains. |[ ]
| **Impotent** (i.e. always unable to obtain and sustain an erection). |[ ]

1. Please provide the **age of onset** for impotence, if any?
2. Please select **all** that apply to any anatomical loss or alteration of the **scrotum**, due to each condition in *isolation*.

| **Description**  | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| Normal. | [ ]  | [ ]  | [ ]  |
| **Symptoms** and/or **signs**. | [ ]  | [ ]  | [ ]  |
| **Anatomical alteration**. | [ ]  | [ ]  | [ ]  |
| **Scrotal malposition**. | [ ]  | [ ]  | [ ]  |
| **Total loss** of scrotum. | [ ]  | [ ]  | [ ]  |

1. Please select **all** that apply to any anatomical loss or alternation of the **testis, epididymis,** and/or **spermatic cord**, due to each condition *in isolation*.

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| Normal. |[ ] [ ] [ ]
| **Symptoms** and/or **signs**. |[ ] [ ] [ ]
| **Anatomical alteration**. |[ ] [ ] [ ]
| **Testes implanted** in non-scrotal position. |[ ] [ ] [ ]
| **Loss of** **one testis**. |[ ] [ ] [ ]
| **Loss of both** **testes**. |[ ] [ ] [ ]

1. Please select **all** that apply to any anatomical loss or alteration of the **prostate and seminal vesicles**, due to each condition *in isolation.*

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| Normal. |[ ] [ ] [ ]
| **Symptoms** and/or **signs**.  |[ ] [ ] [ ]
| **Frequent** and **severe symptoms or signs**. |[ ] [ ] [ ]
| **Anatomical alteration**. |[ ] [ ] [ ]
| **Loss** **of prostate** and/or **seminal vesicles**. |[ ] [ ] [ ]

1. Please select the most accurate description of the **seminal** or **hormonal function**, due to each condition *in isolation.*

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| Normal. |[ ] [ ] [ ]
| **Detectable** **abnormalities**. |[ ] [ ] [ ]
| **Complete loss of function**.  |[ ] [ ] [ ]

1. Please select **all** that apply to any abnormality of the **breasts**.

| **Description** | **Select** |
| --- | --- |
| No abnormality. |[ ]
| Painful **gynaecomastia** that interferes with daily activities. | [ ]  |
| **Galactorrhoea** sufficient to require the use of absorbent pads. |[ ]

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