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| --- | --- | --- | --- | --- |
| Australian Government crest, Department of Veterans' Affairs branding | Female Reproductive System  Medical 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 describe the current **signs and/or symptoms**, due to each condition *in isolation*.

| **Condition** | **Signs and/or Symptoms** |
| --- | --- |
|  |  |
|  |  |
|  |  |

1. Please select **all** that apply of any effect in relation to the **ovaries and/or fallopian tubes**, due to each condition *in isolation*.

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| None. |  |  |  |
| **Unilateral** dysfunction or loss. |  |  |  |
| **Bilateral loss of tubular patency**. |  |  |  |
| **Total failure to produce ova**. |  |  |  |

1. For any dysfunction or loss of the **ovaries and/or fallopian tubes**, did this occur **before** natural menopause?  Yes  No
2. Please select the most accurate description of any effect on the **uterus,** due to each condition *in isolation.*

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| No abnormality. |  |  |  |
| Some **dysfunction**. |  |  |  |
| **Complete functional loss**. |  |  |  |
| **Anatomical loss**. |  |  |  |

1. For any effect on the **uterus**, did this occur **before** natural menopause?  Yes  No
2. Please select the most accurate description of any limitation of **vaginal childbirth**,due to each condition *in isolation*.

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| No abnormality. |  |  |  |
| **Vaginal delivery limited**. |  |  |  |
| **Vaginal delivery not possible**. |  |  |  |

1. For any limitation of **vaginal childbirth**, did this occur **before** natural menopause?  Yes  No
2. Please select the most accurate description of any **cervical stenosis,** due to each condition *in isolation.*

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| None. |  |  |  |
| **Present**, but not requiring treatment. |  |  |  |
| **Requires periodic treatment**. |  |  |  |
| **Complete cervical stenosis**. |  |  |  |

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. |  |  |  |
| **Continuous** treatment. |  |  |  |
| **Not controlled**,despite treatment. |  |  |  |

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

| **Description** | **Select** |
| --- | --- |
| No abnormality. |  |
| **Galactorrhoea** sufficient to require the use of absorbent pads. |  |
| **Loss of one breast**. |  |
| **Loss of** **both breasts** before natural menopause. |  |

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