Medical Update Form

Name:
SSN: xxx-xx-_ _ _ _

Physician/Staff Information

1. Please list the doctors and staff you currently see and the names of the facilities that you **CURRENTLY** go to.

Doctor's/Staff's full name, Address and Telephone Number	Why do you see this doctor?	Treatment Dates (month/year)
(Facility/Clinic/Office Name) (Telephone Number w/ac) (Doctor's/Staff's Full Name) (M.D. or D.O.) (PhD, PA-C or NP) (Street Address) (City) (State) (Zip)		(First Appointment) (Most Recent Appointment) Will you see this doctor for another appointment in the future? **YES** or **NO** (circle one) (Next Visit)
(Facility/Clinic/Office Name) (Telephone Number w/ac) (Doctor's/Staff's Full Name) (M.D. or D.O.) (PhD, PA-C or NP) (Street Address) (City) (State) (Zip)		(First Appointment) (Most Recent Appointment) Will you see this doctor for another appointment in the future? **YES** or **NO** (circle one) (Next Visit)
(Facility/Clinic/Office Name) (Telephone Number w/ac) (Doctor's/Staff's Full Name) (M.D. or D.O.) (PhD, PA-C or NP) (Street Address) (City) (State) (Zip)		(First Appointment) (Most Recent Appointment) Will you see this doctor for another appointment in the future? **YES** or **NO** (circle one) (Next Visit)
(Facility/Clinic/Office Name) (Telephone Number w/ac) (Doctor's/Staff's Full Name) (M.D. or D.O.) (PhD, PA-C or NP) (Street Address) (City) (State) (Zip)		(First Appointment) (Most Recent Appointment) Will you see this doctor for another appointment in the future? **YES** or **NO** (circle one) (Next Visit)

If you need additional space, please use the back of the form

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Hospital Information

2. Please list any emergency room visits or hospitalizations since our last medical update.

Hospital/Urgent Care Name, Address and Telephone Number	Why did you go to this hospital?	Treatment Dates (month/year)
(Name of Hospital/Urgent Care Facility) (Telephone Number w/ac) (Street Address) (City) (State) (Zip)		(Emergency Room) (Inpatient/Hospitalized) (Outpatient)
(Name of Hospital/Urgent Care Facility) (Telephone Number w/ac) (Street Address) (City) (State) (Zip)		(Emergency Room) (Inpatient/Hospitalized) (Outpatient)
(Name of Hospital/Urgent Care Facility) (Telephone Number w/ac) (Street Address) (City) (State) (Zip)		(Emergency Room) (Inpatient/Hospitalized) (Outpatient)

Medications

3. Please list all medications that you are **CURRENTLY** taking.

Name of Medication	Prescribing Doctor

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4. What year did you last file a tax return? _____. How much were your earnings for that year? $ _____.

5. What is your Height? _____ feet _____ inches. Weight? _____ pounds.

6. Describe any significant changes in your condition since our last contact, including any new diagnoses.

_____

_____

_____

7. Are you currently working or have you attempted to work since our last medical update?
If yes, please describe the type of work, number of hours worked, and amount of your wages.

_____

_____

8. Please list all amounts and sources of your current household income.

	You	Your Spouse	Other _____
Tax Refund (annual)	$	$	$
SDA (monthly)	$	$	$
Bridge Card (monthly)	$	$	$
Unemployment (monthly)	$	$	$
Child Support (monthly)	$	$	$
Alimony (monthly)	$	$	$
VA Benefits (monthly)	$	$	$
Workers' Compensation (monthly or lump sum – circle one)	$	$	$
Long/Short Term Disability (monthly)	$	$	$
Other (weekly / monthly / annually – circle one): _____	$	$	$

9. Have you had a change in Marital Status? ☐ Yes ☐ No
I am currently (check one): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

10. Please list your current contact information.

Mailing address: _____
(Street Address) (Apt #)

_____
(City) (State) (Zip)

Telephone Number: (_____)_____ Alternate Telephone Number: (_____)_____

Emergency Contact Information/
Name & Telephone Number (including area code): _____

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Submit