

## 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)
<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Facility/Clinic/Office Name) (Telephone Number w/ac)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Doctor's/Staff's Full Name) (M.D. or D.O.) (PhD, PA-C or NP)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Street Address)</div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black;"> <span>(City)</span> <span>(State)</span> <span>(Zip)</span> </div>		<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(First Appointment)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Most Recent Appointment)</div> <div style="margin-bottom: 5px;">Will you see this doctor for another appointment in the future? <b>YES</b> or <b>NO</b> (circle one)</div> <div style="border-bottom: 1px solid black;">(Next Visit)</div>
<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Facility/Clinic/Office Name) (Telephone Number w/ac)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Doctor's/Staff's Full Name) (M.D. or D.O.) (PhD, PA-C or NP)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Street Address)</div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black;"> <span>(City)</span> <span>(State)</span> <span>(Zip)</span> </div>		<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(First Appointment)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Most Recent Appointment)</div> <div style="margin-bottom: 5px;">Will you see this doctor for another appointment in the future? <b>YES</b> or <b>NO</b> (circle one)</div> <div style="border-bottom: 1px solid black;">(Next Visit)</div>
<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Facility/Clinic/Office Name) (Telephone Number w/ac)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Doctor's/Staff's Full Name) (M.D. or D.O.) (PhD, PA-C or NP)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Street Address)</div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black;"> <span>(City)</span> <span>(State)</span> <span>(Zip)</span> </div>		<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(First Appointment)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Most Recent Appointment)</div> <div style="margin-bottom: 5px;">Will you see this doctor for another appointment in the future? <b>YES</b> or <b>NO</b> (circle one)</div> <div style="border-bottom: 1px solid black;">(Next Visit)</div>
<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Facility/Clinic/Office Name) (Telephone Number w/ac)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Doctor's/Staff's Full Name) (M.D. or D.O.) (PhD, PA-C or NP)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Street Address)</div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black;"> <span>(City)</span> <span>(State)</span> <span>(Zip)</span> </div>		<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(First Appointment)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Most Recent Appointment)</div> <div style="margin-bottom: 5px;">Will you see this doctor for another appointment in the future? <b>YES</b> or <b>NO</b> (circle one)</div> <div style="border-bottom: 1px solid black;">(Next Visit)</div>

## Medical Update Form

Name:

SSN:   XXX-XX-\_\_ \_\_ \_\_

### 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)		(Emergency Room)
(Street Address)		(Inpatient/Hospitalized)
(City) (State) (Zip)		(Outpatient)
(Name of Hospital/Urgent Care Facility) (Telephone Number w/ac)		(Emergency Room)
(Street Address)		(Inpatient/Hospitalized)
(City) (State) (Zip)		(Outpatient)
(Name of Hospital/Urgent Care Facility) (Telephone Number w/ac)		(Emergency Room)
(Street Address)		(Inpatient/Hospitalized)
(City) (State) (Zip)		(Outpatient)

### Medications

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

Name of Medication	Prescribing Doctor

## Medical Update Form

Name: \_\_\_\_\_

SSN:   xxx-xx-\_\_ \_\_ \_\_

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): \_\_\_\_\_