

# MEDICAL HISTORY AND DISABILITY STATEMENT

Instructions: It is very important that you read and answer all questions carefully. Your responses may help to determine if you are disabled. You may ask someone such as a relative, friend, eligibility worker, or someone from the health care field to help you complete this form. If someone helps you to complete the form, the answers should, to the extent possible, be in your own words.

Name of potentially disabled individual: \_\_\_\_\_  
Last Name First Name

DHS Recipient ID Number: \_\_\_\_\_ DHS Case Number: \_\_\_\_\_

## SOCIAL SECURITY DISABILITY INSURANCE (SSDI) INFORMATION

1. Are you receiving SSDI?  Yes  No
2. Have you ever received SSDI?  Yes  No
3. If yes to #2, why did the SSDI stop? \_\_\_\_\_
4. Have you applied for social security benefits for your current disability? Check appropriate block(s):  
 No  
 Yes, Date applied for benefits: \_\_\_\_\_  
 My application is pending.  
 My application has been approved and I am currently or will soon be receiving benefits.  
 My application was denied. Explain reason given for denial of benefits:  
\_\_\_\_\_  
\_\_\_\_\_

## MEDICAL PROFILE

1. Describe your disability and explain the reason(s) why you are unable to work:  
\_\_\_\_\_  
\_\_\_\_\_
2. Describe the cause of your disability (i.e. accident, injury, illness, etc):  
\_\_\_\_\_  
\_\_\_\_\_
3. Describe all treatment(s) prescribed by any physician for your disability:  
\_\_\_\_\_  
\_\_\_\_\_
4. How often do you see your doctor for treatment? (Check one of the following blocks)  
 weekly  several times a month  monthly  quarterly or more
5. List hospitalization(s) within the past two years, reason for hospitalization(s), and duration(s) of stay:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

