

Worksheet 1: Applicant Medical History

FOR PERSONAL USE

The purpose of this worksheet is to help gather all the medical information related to your disability(s) that you need for your Social Security Disability Insurance application. To use this worksheet, collect for yourself as much of the following information as possible and fill out each section below. Refer to the **MS Listing and Criteria Reference Sheet (Appendix E)** on **page 60** to organize information by each MS Listing criterion and symptom that applies to you. **Bring a copy of this worksheet to the appointments with your doctor(s)** to remind him or her of what information to collect and to double check for any missing information. **Bring a copy of this worksheet to your SSA interview** as well and attach any copies of the relevant information you have gathered for the checklist. **KEEP YOUR ORIGINALS.**

- A. List all illnesses, injuries, or conditions that prevent you from working. This should include all symptoms, whether or not they are related to MS.

B. Date you became unable to work in any substantial gainful activity (SGA) because of your medical condition (MM/DD/YY).

C. If you are receiving Medicaid, write your Medicaid ID number in the space. Include a copy of your Medicaid benefit card:

D. List the names of your doctor(s), therapist(s), and other healthcare provider(s) who have treated or examined you for your disability-related illnesses, injuries, or conditions in the past and who you expect to treat you in the future. Also include medical professionals who know about the effects of your MS symptoms even if they didn't treat or examine you for it.

For each practitioner treating your symptoms, please include the following: Name, Specialization, Address, Phone, Reason for Visit, Date First Seen, Date Last Seen

1. Healthcare Providers Treating Motor or Physical Symptoms:

2. Healthcare Providers Treating Vision Symptoms:

3. Healthcare Providers Treating Cognitive or Mental Health Problems:

4. Healthcare Providers Treating Fatigue Symptoms:

E. Hospitals, clinics, MS centers, rehabilitation facilities, or emergency rooms you visited. If you have a hospital number and you know it, include that too. For each instance, please include the following: Name, Address, Phone, Reason for Visit, Date of Admission, Date of Discharge

F. All medications you take and why you take them — not only those used to treat your MS symptoms. Include whether you have any side effects from a medication. Also include medications you have tried before and why they did not work and/or you stopped taking them.

For each medication, please include the following: Name of Medication, Dosage (if known), Length of Prescription, Reason for Taking Medication, Prescribing Physician

G. Medical tests you have had or are going to have related to your MS symptoms and/or other conditions.

For each test, please include the following: Name of Test, Place of Test, Reasons for Test, Name of Healthcare Provider(s) Who Ordered Test, Test Date(s) (MM/DD/YY), Test Results
