DISABILITY QUESTIONNAIRE CONTINUATION SHEET

AGENCY/ADDRESS

New York State **Department of Health**

Name (Last, First, Middle)	Social Security Number *(last 4 digits)*	Case Number

PART II – INFORMATION ABOUT YOUR MEDICAL RECORDS

In order to make a disability determination, current medical evidence is needed to evaluate your physical and/or mental impairments. If you have not seen a medical provider for your impairment(s) within the past 12 months, a consultative exam may be arranged for you by the local agency.

B. Have you seen any other medical provider(s) within the past 12 months? ☐ Yes ☐ No
(If "Yes," please complete the section below.)

Please list the name, address, and phone number of all providers you have seen for the past 12 months (for example, physicians, nurse practitioners/physician assistants, mental health counselors, physical/occupational/speech therapists, audiologists, etc.)

Name	Address	Phone No.	Reason for Seeing:

C. Have you received medical care in a hospital or other health facility within the past 12 months? ☐ Yes ☐ No
(If "Yes," please complete the section below.)

Please list the name and address of all hospitals and other medical facilities at which you have sought treatment in the past 12 months.

Hospital/Facility	Address	Reason: