

# Medical Social Security Benefits Worksheet

## Personal Information

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

Social Security Number (Last 4 digits): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Current Address: \_\_\_\_\_

## Medical Condition(s)

Primary Disability or Medical Condition: \_\_\_\_\_

Additional Conditions (if any): \_\_\_\_\_

Date Condition Began: \_\_\_\_\_

Date You Stopped Working (if applicable): \_\_\_\_\_

## Healthcare Providers

Doctor / Specialist Name	Type (Primary, Specialist)	Clinic / Hospital Name	Contact Info

## Medical Treatments & Tests

List any recent treatments, hospital stays, surgeries, or tests: \_\_\_\_\_

Prescribed Medications: \_\_\_\_\_

Impact on Daily Life: \_\_\_\_\_

## Supporting Documents Checklist

- Doctor's Reports / Medical Records
- Hospital Discharge Summaries
- Prescription History
- Lab or Test Results (X-rays, MRIs, etc.)
- Statement from Employer (if applicable)
- Prior SSA Communication or Decisions