SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals

Form Approved
OMB No. 0960-0289

CLAIMANT'S MEDICATIONS

A. To be completed by Hearing Office

(Claimant and Social Security Number)	(Wage Earner and Social Security Number) (Leave blank if same as claimant)	Thelasttimewebrought your case up-to-date was:
- -	- -	

B. To be completed by the claimant

PLEASE PRINT

PLEASE LIST BELOW THE PRESCRIPTION MEDICATION WHICH YOU ARE PRESENTLY TAKING. IF THE NAME OF THE MEDICATION IS NOT SHOWN ON THE PRESCRIPTION CONTAINER, YOU MAY VERIFY THE NAME WITH YOUR PHARMACIST.

NAME OF MEDICATION & DOSAGE	DATE FIRST PRESCRIBED	DAILY AMOUNT TAKEN	REASON FOR MEDICATION	NAME OF PHYSICIAN

PLEASE LIST BELOW THE NONPRESCRIPTION MEDICATION YOU ARE TAKING AND THE REASONS YOU TAKE THEM.

Form **HA-4632** (10-2012) ef (10-2012)
Use Until Stock Is Exhausted

If more space is needed, use additional sheets.