Social Security Administration
Office of Hearings and Appeals

Form Approved
OMB No. 0960-0292

CLAIMANT'S RECENT MEDICAL TREATMENT

A. To be completed by hearing office

(Claimant and Social Security Number)	(Wage Earner and Social Security Number) (Leave blank if same as claimant)	The last time we brought your case up-to-date was:
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B. To be completed by the claimant

PLEASE PRINT

Please Answer the Following Questions:

(1) Have you been treated or examined by a doctor (other than a doctor at a hospital) since the above date? ☐ Yes ☐ No

(If yes, please list the names, addresses and telephone numbers of doctors who have treated or examined you since the above date. Also list the dates of treatment or examination. If possible, send updated reports from these doctors to the Administrative Law Judge before the date of your hearing.)

DOCTORS NAME(S)	ADDRESS(ES) & TELEPHONE NO.(S)	DATE(S)

(2) What have these doctors told you about your condition?

(3) Have you been hospitalized since the above date? ☐ Yes ☐ No

(If yes, please list the name and address of the hospital. Also, explain why you were hospitalized and what treatment you received.)

Name of Hospital	Address of Hospital (Include ZIP Code)

Reason for hospitalization:

Treatment received:

Form **HA-4631** (6-2010) ef (6-2010)
Destroy Old Stock

If more space is needed, use additional sheets.