# DISABILITY QUESTIONNAIRE CONTINUATION SHEET

AGENCY/ADDRESS

**New York State** **Department of Health**

| Name (Last, First, Middle) | Social Security Number *(last 4 digits)* | Case Number |
|---|---|---|
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## 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: |
|---|---|---|---|
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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: |
|---|---|---|
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