SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals

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):	The last time we brought your case up to date was:______
		(Date is usually when request for hearing was filed) _______________

B. To be completed by the Claimant

PLEASE PRINT

PLEASE LIST BELOW THE PRESCRIPTIONS 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	REASONS FOR MEDICATION	NAME OF PHYSICIAN

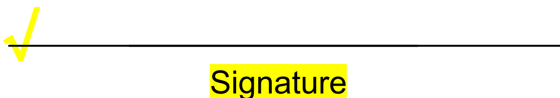
PLEASE LIST BELOW **THE NONPRESCRIPTION MEDICATION YOU ARE TAKING** AND THE REASONS YOU TAKE THEM
ALSO PLEASE LIST YOUR RECENT MEDICAL TREATMENT

OTC Medications:

If more space is needed, use additional sheets.

PLEASE READ THE PRIVACY ACT
STATEMENT ON THE NEXT PAGE

Form HA-4632 (2-94)



Signature

____

Date