DO-050 (7-02)

Disability Determination Service Administration

SYMPTOM QUESTIONNAIRE TO CLAIMANT

{@DMABARMED}

1. Please describe your symptoms (pain, shortness of breath, dizziness, fatigue, etc.): _____

2. If you experience pain, where is it located? _____

3. ___ Yes ___ No Does the pain spread to other parts of the body? If yes, explain: _____

4. If you experience pain, describe what the pain feels like. _____

5. What brings on your symptoms? _____

6. How long do your symptoms last? _____

7. How often do your symptoms occur? _____

Continue on next page

8. ___ Yes ___ No Do the symptoms limit you? If yes, please explain:_____

9. What makes your symptoms go away? _____

10. ___ Yes ___ No Are you using medication? If Yes, for what conditions: _____

11. What is the name of the medication? What is the dosage? _____

12. How does it affect your symptoms? _____

13. ___ Yes ___ No Does the medication produce side effects? If yes, explain: _____

14. What other treatment do you have for relief of the symptoms? _____

15. ___ Yes ___ No Has your address or phone number changed since you filed your claim?

Current mailing address _____
(P.O. Box., No., Street, City, State, ZIP)

_____ Phone No. (_____)_____

Claimants signature _____ Date _____

CLAIMANT - SEIZURE QUESTIONNAIRE

Name: {CFNAME} {CMNAME} {CLNAME} SSN: {CSSN}

1. How long have you been having seizures? _____

2. Date of last seizure _____

3. How long do they last? _____

4. How many seizures have you had in each of the last 6 months?

Month	Number of Seizures
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

5. Do the seizures happen during daytime? _____

At night, while sleeping? _____

6. Describe what happens to you, as far as you remember, just before, during and after a seizure.

_____

_____

_____

7. Do you take medicine regularly as instructed? _____

What is the name of your medicine (s) _____

8. How many times per day do you take each type of medication?

_____

9. Name and address of the doctor, hospital or clinic that gave you this prescription.

_____

10. How often do you get medicine refilled? _____
Give name and telephone number of drug store and prescription number of your medicine.

_____

{@DMABARMED}

11. Have you seen a doctor recently for your seizures? _____

If yes, who and when? _____

12. Has your doctor advised you not to drink alcohol? _____

13. Do you drink alcohol? If yes, how often? _____

14. Do you get seizures when you drink or soon after you drink? _____

15. Do you also get seizures when you are not drinking? _____

16. Has a friend or relative, doctor or other person seen you while you were having a seizure?
_____Yes _____No

If yes, do you authorize this agency to contact this person to obtain information about your seizure condition?
_____Yes _____No

Please give their name, address, telephone number and relationship to you.

_____

_____

USE THIS SPACE TO ADD ANY ADDITIONAL INFORMATION ABOUT YOUR SEIZURES

Your Signature _____Telephone Number _____

HEART QUESTIONNAIRE

TDN: «MER_MER_TDN»

CLAIMANT: «CLAIM_CLM_FML»

We need more evidence about your heart condition. Please COMPLETE, SIGN, AND DATE this questionnaire and return it to us in the enclosed envelope. You may use the reverse side if necessary. Thank you for your cooperation.

1) DO YOU EXPERIENCE CHEST PAIN? YES _____ NO _____
(If you answer "NO", go on to question #9.)

WHEN WAS THE FIRST TIME? HOW OFTEN? WHEN WAS THE LAST TIME?

2) WHERE IS THE PAIN LOCATED?

3) WHAT DOES IT FEEL LIKE?

4) DOES THE PAIN MOVE ANYWHERE ELSE? WHERE?

5) WHAT MAKES YOU GET THIS PAIN?

6) HOW LONG DOES THIS PAIN USUALLY LAST?

7) DO YOU TAKE MEDICATION FOR THE PAIN? YES _____ NO _____
If "YES", name the medication(s):

8. DOES THE PAIN GO AWAY AFTER YOU TAKE YOUR MEDICATION? YES _____ NO _____
If "YES", how long does it take for the pain to go away?

9. HAVE YOU HAD ANY SPECIAL HEART TESTS SUCH AS AN EKG OR TREADMILL TEST?
If so, where and when were they done?

SIGNATURE: _____ DATE: _____

«XMNR_XMNR_1ST»«XMNR_XMNR_2ND»«XMNR_XMNR_SUR»/«GENERA_OP_ID»
HEART (9/04)

[:topdma]

CLAIM #: {CCASENBR}

DMA-**{CORGDMAFLG}**

[@CLMTADDR]

-----DDS RETURN ADDRESS-----
[@DMARTRN]

Attached you will find an ASTHMA QUESTIONNAIRE.

It is necessary for you to complete this form and return it to me within 10 working days.

This is to notify you that if we do not hear from you within 10 Working days of your receipt of this letter, we will process your claim without the additional information. This could result in a denial or cessation of your claim.

A pre-addressed, postage paid envelope is enclosed for your convenience.

Please remove this coversheet prior to returning the questionnaire.

[PFIRSTNAME] [PLASTNAME]
Adjudicator
[@EXPHONE]

[CEXAMINER]/[@OPER]
({CCASENBR})

ENCLOSURE

[@COPY]

[@PAGE]

[redacted]

ASTHMA HISTORY

RE: [CFNAME] [CLNAME] ({CCASENBR})
[CEXAMINER]

{@dmabarmed}

DMA-**{CORGDMAFLG}**/ PFI: **[CPFI]**

[@COPY]

1. How often do you have asthma attacks? _____

2. When was the last attack? _____ The one before that? _____

3. How long did they last? _____ How long do they usually last? _____

4. Please describe your asthma attacks. _____

_____

_____

5. What brings on the attack? _____

_____

6. What time of day do they usually occur? _____

7. What do you do to help yourself? _____

_____

8. How soon after an attack can you get back to your usual activities? _____

_____

9. How many times in the last 12 months have you been hospitalized or taken to the emergency room for an attack? _____ Dates: _____

10. Which hospital or ER did you use? _____

_____

11. What adjustments do you make in your daily activities because of asthma? _____

_____

_____

_____

12. **PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS, INCLUDING OXYGEN**

DOSE IF APPLICABLE:

	Name of Medication	Date Prescribed	Dosage	Frequency	For What?
1.					
2.					
3.					
4.					
5.					
6.					

13. Who prescribes your medication for asthma? _____

14. When did you see this doctor last? _____

15. Do you usually take the medicine as directed by the doctor? _____

Explain: _____

16. Have you had breathing tests? _____ When? _____ Where? _____

_____

Additional Comments: _____

_____

_____

_____

Your Signature: _____ Date: _____

(ASTHMA-A)

[:LTRHEAD]
{Cunitfcd} {Cexaminer}/[@oper] M-44A [@date] ([corgdmaflg]) **Casenbr:** [ccasenbr]
D0044A **[@serial]**

{@clmtaddr} [@DMARTRN]

FAX RESPONSE TO: {AALTPHONE2}, OR
RETURN THE COMPLETED FORM IN THE ENCLOSED BUSINESS REPLY ENVELOPE
PLEASE DO NOT MAIL IF YOU FAX YOUR RESPONSE
THIS PAGE MUST BE ON TOP OF YOUR RESPONSE
PLEASE DO NOT USE ANY OTHER FAX COVER SHEET
[@DMABARMED]

This office is responsible for developing evidence in connection with your [@ss/mn] disability claim. In order for us to fully understand your condition, we need some more information. Please complete this questionnaire, **WHICH BEGINS BELOW**, in as much detail as you can, and sign and date the form. Please complete the form in English. Fax the form to the number above, or mail the form to us in the enclosed business reply envelope within ten days.

If we do not hear from you within ten days from the date of this letter, your claim may be unnecessarily delayed or a decision may be made on your claim based on the information currently in your file. Because we are missing some important information, this could result in a finding that you are not eligible for disability benefits.

SUPPLEMENTAL ANXIETY QUESTIONNAIRE

PLEASE ANSWER THE QUESTIONS ABOUT ANY ANXIETY ATTACKS YOU EXPERIENCE:

1. When did you start having anxiety attacks?

2. What was the date of your last anxiety attack?

[:bottom]

[@copy] Page 1 of 3

[@page]

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[:ATCHTOP]

PLEASE BE SURE YOU ANSWER THE QUESTIONS ON THE FIRST, BARCODED PAGE.

3. How many attacks have you experienced in the last 3 months? _____ How many attacks have you experienced in the last 6 months? _____

4. How long does each attack last?

5. What appears to cause the attacks?

6. What makes the attacks worse?

7. What relieves your symptoms?

8. In your own words, giving as many details as possible, describe what happens during an attack, including what kinds of thoughts you have and what this makes you do.

[@page]

M-44A D0044A (Doc Type 0050)

[:ATCHTOP]

9. How do these attacks affect your ability to function?

PLEASE BE SURE YOU ANSWER THE QUESTIONS ON THE FIRST, BARCODED PAGE.

In case we need to contact you to clarify any of your comments, please provide your telephone number and the best times to call during business hours.

Telephone Number: _____

Days: _____ Times: _____

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

_____ _____

(Your Signature) (Date)

This letter contains information that is confidential under federal and state statutes and is intended to be delivered to only the named addressee. Any unauthorized use of this information may be a violation of criminal statutes. If you received this letter in error, you should immediately notify this agency at the address above or the telephone number below. We will provide you with instructions regarding the disposal of this letter. Under no circumstances should this information be shared, retained, or copied by anyone other than the named addressee.

If you have any questions, please call me between the hours of 9:00 AM and 4:00 PM, Monday through Friday. We appreciate your help in giving us this information.

[:Closing]
[:bottom]

SUBSTANCE ABUSE QUESTIONNAIRE {@DMABARMED}

1. What type of alcohol / drugs do (did) you drink / take? _____

_____

2. How long have you been drinking / taking drugs? _____

_____

3. Have you ever tried to stop drinking / taking drugs? _____

What happened? _____

_____

What made you start again (if you did)? _____

If you are no longer drinking / taking drugs, when did you last drink / take drugs? _____

_____

4. Have you ever been treated at a drug or alcohol treatment program? _____

_____

5. How often do (did) you drink alcohol / take drugs? _____
6. How much alcohol / drugs do (did) you use at one time? _____
7. Have you ever been arrested because of your alcohol / drug problem? _____
8. Do you have and DWI's / drug arrests? _____ How many? _____

DATES: _____

9. Have you ever lost a job because of your alcohol / drug problems? _____

How many and what were the dates? _____

10. How does (did) drinking or drugs affect your behavior? _____

_____

11. Do you think that drinking or drugs has affected your ability to work? _____

How? _____

_____ _____ _____

Signature Telephone No. Date

Address: _____

SSA will insert the following revised PRA Statement into the form at its next scheduled reprinting:

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. The OMB control number for this collection is 0960-0555. We estimate that it will take between 5 to 30 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

PRIVACY ACT STATEMENT
Collection and Use of Information by the Social Security Administration

The Privacy Act of 1974 (5 U.S.C. § 552a) requires us to provide certain facts to each person from whom we request and collect information in order to administer our programs. These facts include:

- the statutory authority for the request;
- why we need the information;
- whether it is voluntary or mandatory for you to give us the information and the effects, if any, of not giving us the information; and
- the uses we may make of the information you give us.

The following sections explain our collection, use, and disclosure of the information you give us. If you have any questions about your rights and responsibilities under the Privacy Act, you may contact any local Social Security office.

Our authority to collect information

Our specific authority to collect information is found in sections 205(a), 702, 1631(e)(1)(A) and (B), 1631(f), 1872, and 1875 of the Social Security Act (the Act), as amended. Additional authority is in part B of the Federal Coal Mine Health and Safety Act of 1969.

Why we need the information

We collect information from you in order to administer our programs. Specifically, the information we request enables us to:

- assign Social Security numbers;
- establish and maintain earnings records;
- determine entitlement of applicants and their families to insurance coverage and or benefit payments;
- issue payments in the right amount for the right months to people entitled to them; and
- conduct program-oriented research in areas of income distribution and maintenance.

Is providing information voluntary or mandatory?

It is not mandatory for you to give us the information we request ***except*** in certain instances explained below. It is usually to your advantage to comply with our request for information. Failure to do so, however, could prevent an accurate and timely decision on a claim you file or result in the loss of some benefit or service.

Our use(s) of the information you give us

We use the information you give us to administer our programs. Sometimes we must disclose the information to another agency or person without your written consent. We make these disclosures for the following reasons:

- to enable a third party or agency to assist us in establishing your right to benefits or coverage;
- to comply with Federal laws;
- to make eligibility determinations in similar Federal, State, and local health and income maintenance programs;
- to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of our programs.

We may also use the information you give us when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use the information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses of the information you give us is available in our Privacy Act Systems of Records Notices. For example, the application for benefits and supporting documentation of the factors of entitlement and continuing eligibility is contained in our Claims Folder System (60-0089); medical information, doctors' reports, and State disability determinations related to a disability claim is contained in our National Disability Determination Services File System (60-0044). Additional information regarding this form, routine uses of information, and other Social Security programs is available from our Internet website at www.socialsecurity.gov or at your local Social Security office.