

# MEDICAL STATEMENT

To be completed by the treating physician  
(PLEASE USE BLOCK LETTERS)



## 1. PATIENT'S INFORMATION

Name	Last	First	M.I.
Date of birth	MM/DD/YY	Height <input type="checkbox"/> M <input type="checkbox"/> Ft	Weight <input type="checkbox"/> Kg <input type="checkbox"/> Lb

## 2. MEDICAL HISTORY

Please provide details about when the condition was diagnosed:

Date of first visit	Symptoms
MM/DD/YY	

Diagnosis

Prognosis

Treatment

Other comments

Have you referred the patient to another specialist or hospital, or know of treatment rendered elsewhere?  Yes  No  
If "Yes", please provide the information requested below.

Physician's name	Telephone
Out-patient treatment	
Hospital	Telephone
Hospital treatment	

### 3. TREATING PHYSICIAN'S INFORMATION

Name					
Address					
Telephone		Fax number		Email	
Date	MM / DD / YY	Signature			