UPDATED MEDICAL CONDITION REPORT (SSA-3441)

******** ***PLEASE COMPLETE THIS FORM AND RETURN IT TO US IN THE POSTAGE PAID ENVELOPE.*** ********

YOUR NAME		**Social Security #**	
Current Address		**Current Phone No.**	

Have there been any **change (for better or worse)** in your illnesses?

Approximate date of the changes	Month	Day	Year	

Do you have any **new illnesses**?

Approximate date of the changes	Month	Day	Year	

Do you have any **new physical or mental limitations** as a result of your illnesses?

Approximate date of the changes	Month	Day	Year	

What changes have occurred in your **daily activities**?

Have you had any **medical tests** or do you have any scheduled?

Have you worked since you last completed a disability report?	YES NO

OTHER REMARKS: (regarding problems such as fatigue, side effects of medication, pain and any other symptoms that cause limitations and reasons you cannot work. This is not the section to make remarks regarding the Social Security system or any other personal problems which are not related to your physical or mental impairments.)

DATE: YOUR NAME: