KS Department of Health and Environment, Presumptive Medical Disability Questionnaire

PLEASE ANSWER EACH QUESTION.

KDHE Use Only
PMDD #_____
KEES Case # _____

Today's Date _____

Social Security Number _____

If you have questions call PMDT at 1-888-547-2763. In Topeka 296-1849. Information can be faxed to 785/296-1723.

1. Complete Name (First, MI, Last): _____

2. Current Address: _____

_____
City State Zip Code

3. Telephone Number Where You Can Be Reached: _____

4. Date of Birth: _____ **5**. Age: _____

6. Height: _____ **7.** Weight: _____

8. Do you understand English? YES ◯ NO ◯ **9.** What language do you prefer? _____

10. Date you applied for Social Security Disability: _____

11. If DDS has scheduled an exam for your Social Security case please fill in the following;

When (Month/Year)	Doctor & Location	Mental or Physical (M or P)

12. Have you been in prison? YES ◯ NO ◯

If yes, please complete the following;

Release Date	Name of Prison	
Location of Prison	City	State

13. Are you able to drive?

◯ YES ◯ NO

If no, please state why not _____

14. Circle the highest grade of school you completed:

1 2 3 4 5 6 7 8 9 10 11 12 GED College: 1 2 3 4 Degree: _____

15. Did you attend special education classes in high school? ◯ YES ◯ NO

If yes, please complete the following;

High School	City	State

16. Please list your jobs.

- ✓ If you are **under 50 years of age**, list the jobs you have had in the past 5 years before you became unable to work.
- ✓ If you are **50 years of age or older**, list the jobs you have had in the past 15 years before you became unable to work.
- ✓ 32 hours or more per week is full time (FT) and less than 32 hours per week is part time (PT).

Job Title (e.g., cook)	Describe your work tasks. How long did you sit, how far did you walk, how much weight did you lift or carry, did you use a computer or other equipment?	Date Started (month/year)	Date Ended (month/year)	Full or Part Time (FT or PT)

17. On what date did you stop working because of your condition? _____

18. List your disabilities or medical conditions that prevent you from working.

19. What activities are you unable to do because of your physical or mental disabilities/conditions?

20. List your doctors for the past year: **If this section is not completed, it will delay your disability determination.**

- ✓ For Date First Seen and Date Last Seen, please list month and year. Add pages if needed

Doctor's Name	Specialty	Name of Clinic/Address/Phone	Date First Seen	Date Last Seen	Next Appt.
Doctor's Name	Specialty	Name of Clinic/Address/Phone	Date First Seen	Date Last Seen	Next Appt.
Doctor's Name	Specialty	Name of Clinic/Address/Phone	Date First Seen	Date Last Seen	Next Appt.

21. List the clinics, hospitals and emergency rooms you have visited in the past year:

Name	Address/Phone/Reason for Visit	Date In	Date Out

22. Have you ever had a psychiatric hospitalization? ◯ YES ◯ NO

23. IF YES, list the most recent: Name of hospital and date last admitted:

24. Have you ever received treatment for substance abuse? ◯ YES ◯ NO

25. IF YES, list the most recent: Name of facility and date last admitted:

26. List your medications and why you take them. Give the doctor's name who prescribes the medication.

Check if taking	What is the name of the medication?	Why do you take it?	Who prescribes it?

27. Do you use a cane, walker, or crutches that your doctor ordered?_____

28. List medical tests you have had or are going to have. When listing body parts, be specific, like, 'right knee.'

Test	Body Part	Date of Test	Where tested?	Who ordered the test?
Biopsy				
Breathing test				
Cardiac Catheterization				
Cardiac testing-EKG				
Cardiac testing-Treadmill				
EEG (brain wave test)				
Mental testing				
Vision Test				
Speech/language test				
MRI/CT Scan				
X-Ray				
Other				

SIGNATURE OF APPLICANT_____

If another person helped complete this form please provide the information below. *For court appointed guardians/conservators, please attach papers appointing you as the legal representative. For third party representatives, such as hospital assistance or mental health centers, please provide authorization signed by the applicant if you would like to speak with PMDT about an individual's case.

Name Phone Number

Agency or Relationship Date