SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0072

CONTINUING DISABILITY REVIEW REPORT

SSA will use this form to review your illnesses, injuries, or conditions since the date of your last medical disability decision.

For SSA Use Only
Do not write in this box.
Date of your last medical disability decision:
7-27-2008

Related SSN _____ - _____ - _____ Number Holder _____

Type(s) of Case(s): (Check all that apply.)

TITLE II	☒ DIB	☐ DWB	☐ CDB	☐ FZ	☐ ESRD	☐ HIB
TITLE XVI	☐ DI	☐ DS	☐ DC	☐ BI	☐ BS	☐ BC

If you are currently participating in the Ticket to Work Program or working under a plan with a private or State Vocational Rehabilitation Agency, contact the Social Security Administration before completing this form.

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

1.A. NAME (first, middle, last) ❶ James Chang

1.B. SOCIAL SECURITY NUMBER 111 - 11 - 1111

1.C. DAYTIME PHONE NUMBER (If you do not have a phone number where we can reach you, give us a daytime phone number where we can leave a message.)

(901) 555 - 5555
(area code) (phone number)

☒ Your number
☐ Message number
☐ None

1.D. E-MAIL ADDRESS (optional)
JChang@dtt.net

1.E. Give the name of a friend or relative (other than your doctors) that we can contact who knows about your illnesses, injuries, or conditions, and can help you with your case.

NAME Sue Chang

RELATIONSHIP Wife

ADDRESS (number, street, apt., PO Box, rural route)
1234 Pasadena Way

CITY Dallas STATE Texas ZIP 82221-

DAYTIME PHONE NUMBER
(901) 555 - 5555
(area code) (phone number)

1.F. Can you speak and understand English? ☒ YES ☐ NO

If "no," what is your preferred language? _____

NOTE: If you cannot speak and understand English, we will provide an interpreter, free of charge.

If you cannot speak and understand English, is there someone we may contact who speaks and understands English and will give you messages? ☐ YES ☐ NO

If "yes," and this is the same person as in "1.E." above, write "SAME" below. If "yes," but this is a different person, complete the information below.)

NAME

RELATIONSHIP

ADDRESS (number, street, apt., PO Box, rural route)

CITY STATE ZIP

DAYTIME PHONE NUMBER
( ) -
(area code) (phone number)

1.G. If you are age 18 or older, can you read and understand English? ☒ YES ☐ NO

1.H. If you are age 18 or older, can you write more than your name in English? ☒ YES ☐ NO

1.I. What is your height without shoes?
5 ft. 8 in.

1.J. What is your weight without shoes?
155 lbs.

❷

SECTION 2- INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

2.A. If you are an adult (age 18 or older), what are the disabling illnesses, injuries, or conditions that limit your ability to work? **If you are a child (under age 18)**, what are the disabling illnesses, injuries, or conditions that limit your ability to do the same things as other children of the same age?

Heart disease--coronary arteries blocked. I had bypass surgery in 2003 at Dallas General Hospital. I also had emphysema and bronchitis.

2.B. Has there been a change (for better or worse) in your illnesses, injuries, or conditions listed in SECTION 2.A., **since the date of your last medical disability decision** (see date on top right side of Page 1)?

☒ YES (Describe specific changes below and give dates when these changes started.)

☐ NO

My chest pain got better after heart surgery, but my shortness of breath got worse. Also, my hearing is worse and I've developed arthritis in my back.

If you need more space, use SECTION 10 - REMARKS.

❸

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS

3.A. Within the last 12 months, have you seen a doctor/hospital/clinic or anyone else for your illnesses, injuries, or conditions?

☒ YES ☐ NO

Do you have a **future appointment** with a doctor/hospital/clinic or anyone else for your illnesses, injuries, or conditions?

☒ YES ☐ NO

3.B. Within the last 12 months, have you seen a doctor/hospital/clinic or anyone else for emotional or mental problems?

☐ YES ☒ NO

Do you have a **future appointment** with a doctor/hospital/clinic or anyone else for emotional or mental problems?

☐ YES ☒ NO

If you answered "No" to both 3.A. and 3.B., do not complete the rest of SECTION 3; skip to SECTION 4.

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS, continued

3.C. List other names, if any, that you have used on your medical records **within the last 12 months**.

N/A

3.D. List each **DOCTOR/HMO/THERAPIST/OTHER PERSON** who has treated you **within the last 12 months.** Also, provide this information for any future appointment(s).

❸

1. NAME: Dr. Stanley Crowe			**DATES**
ADDRESS: 412 11th Street			First Visit **(within last 12 months)**: 10-3-2002
CITY: Dallas	STATE: TX	ZIP: 93870 -	Last Visit: 6-17-2011
PHONE: (214) 555 - 5555 (area code) (phone number)	PATIENT ID# (if known)		Next Appointment: 9-23-2011
Reasons for visits: Check-ups on my heart	What treatment was received?: Drugs for chest pain. Then bypass surgery when drugs didn't work. Don't need heart drugs now.		
2. NAME: Dr. Glen Rose			**DATES**
ADDRESS: The Pulmonary Clinic, 82 Oak Cove			First Visit **(within last 12 months)**: 4-2-2002
CITY: Dallas	STATE: TX	ZIP: 93872 -	Last Visit: 3-8-2011
PHONE: (214) 555- 6666 (area code) (phone number)	PATIENT ID# (if known)		Next Appointment: 2-8-2012
Reasons for visits: Check-ups for my emphysema and bronchitis.	What treatment was received?: Drugs to help widen my airways--theophylline.		

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS, continued

DOCTOR/HMO/THERAPIST/OTHER

3. NAME			DATES
Dr. Jane Barr			
ADDRESS The Orthopedic Specialists			First Visit **(within last 12 months)** 7-1-2011
CITY 902 Freeway Drive Dallas	STATE TX	ZIP 93875	Last Visit 7-1-2011
PHONE (214) 555 - 7777 (area code) (phone number)	PATIENT ID# (if known)		Next Appointment None

Reasons for visits	What treatment was received?
Back pain.	Darvocet for pain.

❸ **If you need more space, use SECTION 10 - REMARKS.**

3.E. List each **HOSPITAL/CLINIC** where you received treatment **within the last 12 months**. Also, provide this information for any future appointment(s).

1. NAME			PHONE ( ) - (area code) (phone number)
See above. See Remarks.			
ADDRESS			PATIENT ID # (if known) / NEXT APPOINTMENT
CITY	STATE	ZIP -	What doctor(s) do you regularly see here?

TYPE OF VISIT	DATES (within the last 12 months)		REASON FOR VISIT(S)	TREATMENT RECEIVED
	Date In	Date Out		
Inpatient Stays (stayed at least overnight)				
Outpatient Visits (sent home the same day)	First Visit	Last Visit	REASON FOR VISIT(S)	TREATMENT RECEIVED
Emergency Room Visits	Date(s) of Visit(s)		REASON FOR VISIT(S)	TREATMENT RECEIVED

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS, continued

HOSPITAL/CLINIC

2. NAME	PHONE ( ) – (area code) (phone number)	
ADDRESS	PATIENT ID # (if known)	NEXT APPOINTMENT
CITY / STATE / ZIP –	What doctor(s) do you regularly see here?	

TYPE OF VISIT	DATES (within the last 12 months)		REASON FOR VISIT(S)	TREATMENT RECEIVED
	Date In	Date Out		
Inpatient Stays (stayed at least overnight)				
Outpatient Visits (sent home the same day)	First Visit	Last Visit	REASON FOR VISIT(S)	TREATMENT RECEIVED
Emergency Room Visits	Date(s) of Visit(s)		REASON FOR VISIT(S)	TREATMENT RECEIVED

3. NAME	PHONE ( ) – (area code) (phone number)	
ADDRESS	PATIENT ID # (if known)	NEXT APPOINTMENT
CITY / STATE / ZIP –	What doctor(s) do you regularly see here?	

TYPE OF VISIT	DATES (within the last 12 months)		REASON FOR VISIT(S)	TREATMENT RECEIVED
	Date In	Date Out		
Inpatient Stays (stayed at least overnight)				
Outpatient Visits (sent home the same day)	First Visit	Last Visit	REASON FOR VISIT(S)	TREATMENT RECEIVED
Emergency Room Visits	Date(s) of Visit(s)		REASON FOR VISIT(S)	TREATMENT RECEIVED

If you need more space, use SECTION 10 - REMARKS.

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS, continued

If you are under age 18, do not complete question 3.F. or SECTION 4; skip to SECTION 5 - TESTS.

❸ **3.F.** Does anyone else (for example, Workers' Compensation, insurance company, prisons, attorneys, or welfare agency) have medical records or information about your illnesses, injuries, or conditions, **within the last 12 months**? Also, provide this information if you are scheduled to see anyone in the future.

☐ YES (Complete the following information.) ☒ NO (Skip to SECTION 4.)

NAME			DATES
ADDRESS			FIRST VISIT **(within the last 12 months)**
CITY	STATE	ZIP –	LAST VISIT
PHONE ( ) – (area code) (phone number)			NEXT APPOINTMENT
CLAIM NUMBER (if any)			NAME OF CONTACT PERSON
REASONS FOR VISITS			

If you need more space, use SECTION 10 - REMARKS.

SECTION 4 - MEDICATIONS

Are you taking any medications for your illnesses, injuries, or conditions?

❹ ☒ YES (Complete the following information. Look at your medicine containers, if necessary.)

☐ NO (Skip to SECTION 5.)

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	ANY SIDE EFFECTS YOU HAVE
Theophylline	Dr. Rose	Bronchitis	None
ibuprofen	N/A	Back pain	Stomach hurts

If you need more space, use SECTION 10 - REMARKS.

SECTION 5 - TESTS

Within the last 12 months, have you had any of the following tests for your illnesses, injuries, or conditions? Also, provide this information if you are scheduled for tests in the future.

❺ ☐ YES (Complete the following information, give approximate dates, if necessary.)
☒ NO (Skip to SECTION 6.)

KIND OF TEST	WHEN WAS/ WILL TEST BE DONE? (month, day, year)	WHERE DONE? (name of facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)	6-17-11	Dr. Crowe's office	Dr. Crowe
TREADMILL (EXERCISE TEST)	"	"	"
CARDIAC CATHETERIZATION			
BIOPSY - Name of body part _____			
HEARING TEST	6-21-2011	Dr. Sanchez's office	Self
SPEECH/LANGUAGE TEST	"	"	"
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST	3-8-2011	Dr. Rose's office	Dr. Rose
X-RAY -- Name of body part _____	Chest x-ray	Dr. Crowe's office	Dr. Crowe
MRI/CT SCAN -- Name of body part _____			

If you need more space, use SECTION 10 - REMARKS.

SECTION 6 - EDUCATION/TRAINING INFORMATION

Complete SECTION 6 if you are age 18 years old or older.

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6.A. Check the highest grade of school completed.

School: None ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☒ GED ☐

College: 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

Approximate date completed: 1972

6.B. Since the date of your last medical disability decision (see date on top right side of Page 1), have you completed or will you complete any type of special job training, trade or vocational school?

☐ YES (Complete the following information.) ☒ NO

NAME OF SCHOOL			
ADDRESS			PHONE ( ) - (area code) (phone number)
CITY	STATE	ZIP -	
TYPE OF PROGRAM			
APPROXIMATE DATE COMPLETED (or will complete)			

If you need more space, use SECTION 10 - REMARKS.

SECTION 7 - UPDATED WORK INFORMATION

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If you are under age 14, skip to SECTION 10 - REMARKS.

If you are age 14 or older, complete SECTION 7.A., and as appropriate, B., C., and D. only. Then skip to SECTION 10 - REMARKS.

If you are age 16 or older, complete all of SECTION 7.

7.A. ARE YOU WORKING NOW?

- ☐ **Full-time** (Skip to Question 7.D.)
- ☐ **Part-time** (Skip to Question 7.D.)
- ☒ **Not working now** (Continue to Question 7.B.)

7.B. If you are not working now, did you work **since the date of your last medical disability decision** (see date on top right side of Page 1).

- ☐ YES (Go to Question 7.C.)
- ☒ NO (Skip to Question 7.E.)

7.C. If you are not working now, do you believe that your medical condition has improved?

- ☐ YES
- ☒ NO

7.D. If you have worked at any time **since the date of your last medical disability decision** (see date on top right side of Page 1), complete the following information for each job you have done. List the most recent job first.

		JOB 1	JOB 2	JOB 3
JOB TITLE (example: cook)				
TYPE OF BUSINESS (example: restaurant)				
JOB DESCRIPTION				
DATES WORKED (month and year)	FROM:			
	TO:			
HOURS PER DAY				
DAYS PER WEEK				
RATE OF PAY (per hour, day, week, month, or year)				
REASON YOU STOPPED WORK				

If you need more space, use SECTION 10 - REMARKS.

SECTION 7 - UPDATED WORK INFORMATION, continued

7.E. If you are not working, do you believe that you are able to work?

- ☒ No, I don't believe that I am able to work at this time.
- ☐ Yes, and I believe that I do **not** have limitations or restrictions on my ability to work.
- ☐ Yes, but I believe that I have limitations or restrictions on my ability to work. (Please explain.)

7.F. Has your doctor(s) told you that you are able to work?

- ☐ No (Skip to Section 8.)
- ☒ Did not say (Skip to Section 8.)
- ☐ Yes, and my doctor(s) did **not** place limitations or restrictions on my ability to work.
- ☐ Yes, but my doctor(s) placed limitations or restrictions on my ability to work. (Please explain. If the same as 7.E., write "same" here.)

See remarks. I was given limitations.

7.G. What is the name(s) of the doctor(s) who said you were able to work?	**7.H.** According to your doctor, when were/are you able to begin work?
(Please make sure that this doctor(s) is listed in SECTION 3.)	

If you need more space, use SECTION 10 - REMARKS.

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SECTION 8 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Complete SECTION 8 if you are age 18 years old or older.

8.A. Since the date of your last medical disability decision (see date on top right side of Page 1), have you participated, or are you participating, in the **Ticket to Work Program**, a plan with a private or State Vocational Rehabilitation Services, an employment network, or any other support services to help you go to work? ☐ YES (Complete the following information.) ☒ NO (Skip to SECTION 9.)

NAME OF ORGANIZATION			
NAME OF COUNSELOR			
ADDRESS			PHONE
CITY	STATE	ZIP –	( ) – (area code) (phone number)

8.B. When did you start participating in the plan?

8.C. Are you still participating in the plan?

☐ YES

☐ NO. I completed the plan _____
(date completed)

☐ NO. I stopped participating in the plan before completing it. (Please explain why you are no longer participating.)

8.D. Types of services or tests provided (for example: intelligence or psychological testing, vision, physicals, hearing, workshops, schools, colleges):

If you need more space, use SECTION 10 - REMARKS.

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SECTION 9 - INFORMATION ABOUT YOUR DAILY ACTIVITIES

Complete SECTION 9 if you are age 18 years old or older.

9.A. Describe what you do in a typical day.

I get up, take a shower and then eat breakfast. I can't sleep too long because of back pain. After breakfast I take the dog for a walk but can't go over about 3 blocks and that takes 30 minutes, because I get short of breath and my back starts hurting more.
Then I come back and sit on the front porch on a recliner to keep my back from hurting. I talk to neighbors if they walk by and watch the neighbor's kid cut my front lawn as I can't do it anymore. In the afternoon I take a nap or go with my wife to the store. I don't lift anything heavy. If it's cold, I stay inside. At night I read or watch T.V., but I have to stand up frequently to keep my back from hurting by sitting in one position too long.

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SECTION 9 - INFORMATION ABOUT YOUR DAILY ACTIVITIES, continued

B. Do you have difficulty doing any of the following? (Please explain any "Yes" answers.)

)ressing	☒ No	☐ Yes	
athing	☒ No	☐ Yes	
aring for hair	☒ No	☐ Yes	
aking medicine	☒ No	☐ Yes	
reparing meals	☒ No	☐ Yes	
eeding self	☒ No	☐ Yes	
oing chores (inside/outside house)	☐ No	☒ Yes	Only light stuff; no bending.
riving or using public transportation	☒ No	☐ Yes	Back pain if drive too long.
hopping	☒ No	☐ Yes	Not more than couple hours.
lanaging money	☒ No	☐ Yes	
/alking	☐ No	☒ Yes	Short of breath if walk too fast.
tanding	☒ No	☐ Yes	If less than 2 hours at a time.
fting objects	☐ No	☒ Yes	Over 20 lbs. hurts back.
sing arms	☒ No	☐ Yes	
sing hands or fingers	☒ No	☐ Yes	
itting	☐ No	☒ Yes	Back pain if over 2 hours.
eeing, hearing, or speaking	☐ No	☒ Yes	Some problems understanding even with aids.

❾

SECTION 9 - INFORMATION ABOUT YOUR DAILY ACTIVITIES, continued

9.B. (continued) Do you have difficulty doing any of the following? (Please explain any "Yes" answers.)

Concentrating	☒ No	☐ Yes	
Remembering	☒ No	☐ Yes	
Understanding/following directions	☒ No	☐ Yes	
Completing tasks	☐ No	☒ Yes	If have back pain.
Getting along with people	☒ No	☐ Yes	

9.C. Do you use an assistive device (for example: eye glasses, hearing aids, braces, canes, crutch(es), walker, wheelchair)?

☒ NO

☐ YES (Please describe what kind, when and how you use it.)

9.D. Do you have hobbies or interests?

☒ NO Used to grow garden; hurts back now.

☐ YES (Please describe what they are and how much time you spend doing them.)

If you need more space, use SECTION 10 - REMARKS.

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SECTION 10 - REMARKS

Please provide any additional information you did not show in earlier parts of this form. You may also attach any medical records, copies of prescriptions, or any other records about your current illnesses, injuries, or conditions you have at home that you wish to give us. When you are finished, or if you don't have anything to add, be sure to complete the information below.

I also saw Dr. Holly Sanchez, ENT Specialists, 434 North Spruce Street, Dallas, TX, 93870. I saw her twice: 4-3-2011 and 6-21-2011. I have no return appointment. I was treated for hearing loss with aids. I hear much better, but still have trouble understanding words when many people are talking or there is a lot of background noise.

#2 Dr. Rose said if I over-exerted I could be in danger from my heart not getting enough oxygen, due to my lung disease. He also said I should avoid dust & fumes. (I worked on farms for 25 years and was exposed to dust all the time.) Additionally, he said that because of my advanced heart and lung disease, I should avoid very hot or cold environments.

#3 Dr. Barr said I had severe arthritis in my spine as well as degenerated discs. She said that I should not lift over 20 lbs and that I should avoid excessive bending of my back. She also said I should avoid activities that jar my back, like riding heavy equipment like tractors.

Dr. Barr said that there was no surgery that could be done on my back. I tried to get some rehabilitation training, but was just too short of breath to keep attending courses.

Date Form Completed (month, day, year)
9-20-2011

If the person completing this form is NOT the disabled person, please complete the following information.

Name (please print)

Address (number and street)			**E-mail address** (optional)
City	**State**	**ZIP** -	**Relationship to disabled person**