

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Recipient's Name]

[Recipient's Title]

[Medical Facility/Practice Name]

[Facility Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to submit my updated medical history for your records. Please find the detailed information regarding my health status and any changes since my last visit.

## **Personal Details**

**Date of Birth:** [Your Date of Birth]

**Patient ID (if applicable):** [Your Patient ID]

## **Medical History Updates**

- **Condition:** [Condition Name] - [Details]
- **Medication:** [Medication Name] - [Dosage and Frequency]
- **Allergies:** [Allergy Details]
- **Surgeries:** [Surgery Details]

If you require any further information or documentation, please do not hesitate to contact me. Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Signature (if sending a hard copy)]