Patient History Verification

Date: [Insert Date]

To: [Healthcare Provider's Name]

Address: [Healthcare Provider's Address]

Patient Name: [Patient's Full Name]

Date of Birth: [Patient's Date of Birth]

Patient ID: [Patient's ID]

Dear [Healthcare Provider's Name],

I am writing to request a comprehensive verification of the medical history for **[Patient's Full Name]**.

Below is the information needed for verification:

- Previous diagnoses
- Medications taken
- Allergies
- Surgeries and procedures
- Doctor's visits

Please provide records from [Start Date] to [End Date] at your earliest convenience. This information is crucial for our ongoing treatment plan.

Thank you for your cooperation.

Sincerely,

[Your Name]

[Your Title/Position]

[Your Contact Information]