Medical History Check Request

Date: [Insert Date]

[Recipient's Name]

[Recipient's Title]

[Healthcare Facility/Organization Name]

[Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to request a comprehensive medical history check for [Patient's Name], who is currently under my care. The purpose of this request is to ensure that [he/she/they] receives appropriate and safe treatment.

Below are the relevant details regarding the patient:

- **Full Name:** [Patient's Full Name]
- **Date of Birth:** [Patient's DOB]
- **Insurance Information:** [Patient's Insurance Information]
- **Contact Number:** [Patient's Contact Number]

I would appreciate it if you could provide the medical history pertinent to [Patient's Name], including any previous diagnoses, treatments, medications, and any other relevant information. Please forward the medical records to my office at your earliest convenience.

Thank you for your cooperation and assistance in this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Medical Practice/Organization Name]

[Your Address]

[City, State, Zip Code]

[Your Contact Number]