



**ATTENTION  
PARAMEDICS  
IMPORTANT MEDICAL**

**INFORMATION ABOUT:** \_\_\_\_\_

**(Update medication after each doctor visit.)**

**EMERGENCY MEDICAL SERVICES**

*(Name of your Emergency Medical Service)* \_\_\_\_\_

*(Enter here your EMS phone number)* \_\_\_\_\_

**PATIENT MEDICAL INFORMATION SHEET**

Date of Form \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Family Physician \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**MEDICAL HISTORY (i.e. Diabetes, Asthma, Heart Attack, etc.)**

Illness \_\_\_\_\_ Date of Onset \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Illness \_\_\_\_\_ Date of Onset \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Illness \_\_\_\_\_ Date of Onset \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Illness \_\_\_\_\_ Date of Onset \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Illness \_\_\_\_\_ Date of Onset \_\_\_\_ / \_\_\_\_ / \_\_\_\_

CURRENT MEDICATIONS

Name _____	Dose _____	Began ____/____/____
Name _____	Dose _____	Began ____/____/____
Name _____	Dose _____	Began ____/____/____
Name _____	Dose _____	Began ____/____/____
Name _____	Dose _____	Began ____/____/____
Name _____	Dose _____	Began ____/____/____

( ) Check here if additional medications are being listed on back of form

Any allergies to medications? ( ) Yes ( ) No

Please list, if any: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PREVIOUS SURGERIES:

Nature _____	Date ____/____/____
Nature _____	Date ____/____/____
Nature _____	Date ____/____/____

Is a current DNR (Do Not Resuscitate) Order in effect? ( ) Yes, ( ) No, Copy Attached ( )

(Note - Out-of-hospital DNR Orders should be no more than 3 months old)

Please list additional medications or any other information that would help us in treatment:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For emergency ambulance service, see: *(Enter here your ambulance service and its phone number.)*

\_\_\_\_\_