Personal Medical Information Card

Life Saving Information For Emergencies

I certify that the information on this form is accurate and up-to-date. I also understand that emergency medical personnel may rely on this information and I agree not to hold emergency personnel responsible for inaccurate or out of date information. **This is not a POLST.**

DATE COMPLETED: ______________________ SIGNATURE: ____

PATIENT INFORMATION:

Name:		Date of Birth:
Address:		Sex: Male Female
City:	State:	Zip Code:
Phone: ( )		

Primary Medical Problems:	
Doctor's Name:	Doctor's Phone:
Hospital Preference:	Have you been a patient there: Yes No

HEALTH INFORMATION:

Allergies to medications:	
Other allergies:	
Current Medications: Name/Dose	
Do you have a pacemaker: Yes No	Blood Type:
Do you have a POLST? Yes No Where is it?	

PREVIOUS MEDICAL PROBLEMS: ***(Check all that apply)***

- ❑ Heart
- ❑ Epilepsy
- ❑ Stroke
- ❑ Glaucoma
- ❑ Asthma
- ❑ Hemophilia
- ❑ Diabetes
- ❑ Hypoglycemia
- ❑ Seizures
- ❑ Emphysema
- ❑ AIDS
- ❑ Anemia
- ❑ Cancer
- ❑ Low Blood Pressure
- ❑ High Blood Pressure
- ❑ Others ____

EMERGENCY REFERENCES:

Name:	Phone:
Address:	Relation:
Name:	Phone:
Address:	Relation:

Vital Signs: Blood Pressure: ____________________________

Oxygen Saturation: __________________________

Pulse Rate: ______________________________