ATTENTION PARAMEDICS

IMPORTANT MEDICAL INFORMATION

NAME _____ DOB _____ SEX_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CURRENT ILLNESSES/CONDITION

_____

_____

_____

_____

_____

PACEMAKER YES ☐ NO ☐

PREFERRED HOSPITAL

_____

CURRENT PRESCRIPTION & NON-PRESCRIPTION MEDICATION

_____

_____

_____

_____

_____

_____

_____

ADDITIONAL DOCTOR INFO & PHONE NUMBER

1. _____

SPECIALTY _____

2. _____

SPECIALTY _____

3. _____

SPECIALTY _____

ALLERGIES TO ANY MEDICATIONS?

_____

_____

_____

_____

_____

_____

HOSPITALS WHICH HAVE YOUR RECORDS _____

MAJOR SURGERIES YOU HAVE HAD (MONTH/YEAR) _____

_____

_____

IN CASE OF EMERGENCY:

NAME _____ RELATIONSHIP _____

PHONE (1) _____ PHONE (2) _____

NAME _____ RELATIONSHIP _____

PHONE (1) _____ PHONE (2) _____

LIVING WILL YES ☐ NO ☐ DURABLE POWER OF ATTORNEY FOR HEALTH CARE YES ☐ NO☐

STATE OF OHIO COMFORT CARE ORDERS YES☐ NO ☐

DO NOT RESUSCITATE (DNR) ORDERS YES ☐ NO ☐