Personal Medical Information

Name: _____ Birth Date: _____
Primary Care Physician:_____ Telephone Number: _____
Specialists:
Type: _____ Name:_____ Type: _____ Name:_____
Type: _____ Name:_____ Type: _____ Name:_____

Current Medical Conditions:

☐ Asthma/COPD Emphysema	☐ Heart Attack
☐ Congestive Heart Failure	☐ Pacemaker
☐ Stroke	☐ Dysrhythmia/Irregular Beats or rhythm
☐ Seizure	☐ Pacemaker/Defib
☐ Diabetes	☐ Hide Blood Pressure
☐ Cancer	☐ Kidney Problems

Other Medical Problems:

_____

_____

_____

_____

_____

What Medications Do You Take?

Drug Name	Dose and Frequency	Drug Name	Dose and Frequency

What Allergies do you have? ☐ No Known Drug Allergies ☐ Drug Allergies (please list)

Contact Information

Emergency Contact
Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact
Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Insurance Information:
Company: _____ Policy/Id#: _____

Company: _____ Policy/Id#: _____

Company: _____ Policy/Id#: _____

Please use the back for additional information. We recommend that you have at least 2 copies of this form. One is for your records and the other to be given to Emergency Medical Services.