Medical Information Form

PATIENT INFORMATION:

Name:		Date of Birth:
Address:		Gender (circle one) Male Female
City:	State:	Zip Code:
Phone:		Social Security #

Primary Medical Diagnosis:		
Physician's Name:		Physician's Phone:
Hospital Preference:		Have you been a patient there? (circle one) Yes No
Medicare #	Other Health Insurance:	Policy #
Address:		Group #

HEALTH INFORMATION:

Current Medications / Dosage / Allergies / Etc.
(attach separate list if needed)

Medical History:

- ☐ Heart
- ☐ Stroke
- ☐ Asthma
- ☐ Seizures
- ☐ Diabetes
- ☐ Cancer
- ☐ Hepatitis
- ☐ Anemia
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pacemaker / Defib
- ☐ Hypoglycemia
- ☐ Emphysema
- ☐ AIDS
- ☐ Psychiatric
- ☐ Fainting
- ☐ Severe Allergy
- ☐ Hemophilia

Allergies to Medication:
Do you have an Advanced Directive, DNR or Out of Hospital (OOH) DNR? (circle one) Yes No
Where is it?

EMERGENCY CONTACTS:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

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personnel may rely on this information and I agree not to hold emergency personnel responsible for inaccurate or out of date information.

SIGNATURE (REQUIRED) _____ **DATE COMPLETED** _____

PLEASE ATTACH A RECENT PHOTOGRAPH AND LIST OF ANY OTHER INFORMATION TO THIS FORM

Additional File of Life kits can be picked up at Stratford EMS Headquarters during normal business hours,
2712 Main Street, Stratford, CT 06615