

Medical Emergency Information

Personal Information

Last Name		First Name		Middle Initial
Date of Birth	Sex	Weight	Blood Type	
Address				
City		State	Zip Code	
Primary Insurance Co.		Secondary Insurance Co.		
Primary Insurance Numbers & Group		Secondary Insurance Numbers & Group		

Past Medical History

Allergies	Cardiac	Surgery
<input type="radio"/> None <input type="radio"/> Unknown Medical Allergies: _____ _____ _____ _____ _____ _____	<input type="radio"/> None <input type="radio"/> Unknown <input type="radio"/> Angina <input type="radio"/> Arrhythmia <input type="radio"/> Cardiomyopathy <input type="radio"/> CHF <input type="radio"/> Congenital <input type="radio"/> Implanted Defib <input type="radio"/> MI Other _____	<input type="radio"/> None <input type="radio"/> Unknown <input type="radio"/> Abdominal <input type="radio"/> Heart <input type="radio"/> Lung <input type="radio"/> Neurological Other _____ _____ _____

Chronic Illnesses

<input type="radio"/> None <input type="radio"/> Asthma <input type="radio"/> Bleeding Disorder <input type="radio"/> Cancer <input type="radio"/> COPD <input type="radio"/> CVA / TIA <input type="radio"/> Diabetic	<input type="radio"/> Dialysis/Renal <input type="radio"/> Gastrointestinal <input type="radio"/> Headaches <input type="radio"/> Hepatitis <input type="radio"/> HIV + <input type="radio"/> Hypertension <input type="radio"/> Paralysis	<input type="radio"/> Psychological <input type="radio"/> Seizures <input type="radio"/> Substance Abuse <input type="radio"/> TB <input type="radio"/> Unknown Other _____ _____
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Current Medications

None Unknown _____

Emergency Contact Information

Primary Physician	Physician Phone Number
Primary Contact Name & Relationship	Primary Contact Phone Numbers
Secondary Contact Name & Relationship	Secondary Contact Phone Numbers

DON'T SEND WITH AMBULANCE!

Update information regularly! Use a separate sheet for additional information.

