Patient Medical History Form

The information provided below will enable medical crews to more accurately and efficiently provide care in an emergency.

Patient Name: _____

Home Address: _____

City/ Town: _____

State: _____ **Zip:** _____

Phone:_____ **Alternate Phone:** _____

Social Security Number: _____ **Date of Birth:** _____

Emergency Contact: _____

Past Medical History

Cardiac: _____

High Blood Pressure: _____

Respiratory: _____

Strokes: _____

Diabetes: _____

Cancer: _____

Other Chronic Medical Problems: _____

_____

_____

_____

Recent Surgeries: _____

_____

Please list any medications taken regularly:

_____

_____

_____

_____

_____

_____

Please list any allergies:

_____

_____

_____

_____

_____

_____

Please place this form where first responders can access it easily (on refrigerator, back of front door).