Personal Medical Information Card

Life Saving Information for Emergencies

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personnel may rely on this information and I agree not to hold emergency personnel responsible for inaccurate or out-of-date information.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

Date Completed: ______________________ Signature: ____

PATIENT INFORMATION:

Name:		Date of Birth:
Address:		Sex: Male Female
City:	State:	Zip Code:
Phone:		

Primary Medical Problems:	
Doctor's Name:	Doctor's Phone
Hospital Preference:	Have you been a patient there? Yes No

HEALTH INFORMATION:

Allergies to medications:		
Other Allergies:		
Current Medications: Name/Dose		
Do you have a pacemaker? Yes No		Blood Type:
Do you have a POLST? Yes No	Where is it?	

PREVIOUS MEDICAL PROBLEMS: (***Check all that apply***)

Heart	Epilepsy	Stroke	Glaucoma
Asthma	Hemophilia	Diabetes	Hypoglycemia
Seizures	Emphysema	AIDS	Anemia
Cancer	Low Blood Pressure	High Blood Pressure	

Others ____

EMERGENCY REFERENCES:

Name:	Phone:
Address:	Relation:
Name:	Phone:
Address:	Relation:

Vital Signs:

Blood Pressure: ______________________

Oxygen Saturation: ______________________

Pulse Rate: ______________________

Please write below any comments or instructions, which would be helpful to emergency responders in assisting you during a personal emergency. Attach a photograph of yourself so Emergency Personnel can match the information to the correct person.

ADDITIONAL INFORMATION:

Place Photo Here

Emergency Medical Information

www.ci.medford.or.us