FAIRFAX COUNTY FIRE & RESCUE DEPARTMENT

(USE **PENCIL** FOR EASE IN MAKING CHANGES)

Dial 9-1-1 for Emergencies

Date Form Completed/Updated:			
	Name:		Sex: M☐F☐
	Address:		
	City:	State:	Zip:
Date of Birth:			
Language Spoken:			
Physician:		Phone #:	
Specialty Physician:		Phone #:	

EMERGENCY CONTACT

Name:	Phone #:
Relationship:	

CURRENT MEDICAL DATA

Communicable Disease(s):

Do you have a DNR form? ☐ YES NO☐ Where?

MEDICATIONS

(Attach additional page if necessary)

Name	Dosage	Frequency	Reason

ALLERGIES

None/NKDA, Penicillin, Sulfa, Iodine, Morphine, Contrast, Other (please list)

MAJOR RECENT SURGERY

Please List:

MEDICAL CONDITIONS

(Check all that exist)

- ☐ No Known Medical Conditions
- ☐ Abnormal EKG/Dysrhythmias
- ☐ Angina
- ☐ Alcohol Consumption
- ☐ Drinks/week _____
- ☐ Asthma
- ☐ Bleeding/Clotting Disorder
- ☐ Bypass/CABG
- ☐ Blood Thinner
- ☐ Medication? _____
- ☐ Cancer
- ☐ Where? _____
- ☐ When? _____
- ☐ CHF
- ☐ COPD/ Emphysema
- ☐ Dementia
- ☐ Diabetes
  - ☐ Insulin Dependent
  - ☐ Oral Medication
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Hard of Hearing
- ☐ Heart Attack/MI
- ☐ Stent
- ☐ Date? _____
- ☐ Home Oxygen
- ☐ LPM? _____
- ☐ Hypertension/High BP
- ☐ Hypotension/ Low BP
- ☐ Kidney Disease
  Dialysis? Yes☐ No☐
- ☐ Pacemaker/ ICD
- ☐ Manufacturer?
  _____
- ☐ Seizure Disorder
- ☐ Smoker
- ☐ Packs/ Day _____
- ☐ Sickle Cell Anemia
- ☐ Stroke/CVA/TIA
- ☐ When? _____
- ☐ Deficit? _____
- ☐ Other: _____
  _____

OTHER INFORMATION

Medical Insurance Co.:	
Policy #:	Phone #:
Medicare #:	Medicaid #:
Living Will/Advanced Directives on file at:	
Health Care Power of Attorney:	
Name:	Phone #:

www.fairfaxcounty.gov/fire-ems