Wood River Fire Department

Patient Medical Records

Patient Information

Last Name	**First Name**	**Initial**	**Age**	**D.O.B.** / /	□ **Male** □ **Female**
Patient Home Address	**Phone #** ( ) -	**City of Residence**	**State**	**Zip Code**	

Emergency Contact	**Patient's Physician**	**Allergies**	**Past Medical History**	
Name: Phone # Relationship:	Name: Phone # Location:	□ No Known Allergies □ List Below:	□ Allergies □ Asthma □ Behavioral □ Cancer □ Other :_____	□ Cardiac □ COPD □ CVA □ Diabetes

□ **Unknown**
□ Drug/ETOH
□ Hypertension
□ Seizures

Explain Medical History: (if needed)

_____

_____

_____

Current Medications Being Taken

Name of Drug/Medication	Dosages	Reason for taking Drug/Med

** *If more space needed for listing Drug/Medication use reverse side.***

Advanced Directives

Do you have a Living Will? Yes / No
Do you have a DNR? Yes / No
Do you have a Medical Power of Attorney? Yes / No
If "Yes" who is your Medical PoA? _____
Which Hospital do you prefer to be transported to: _____

Note: This is not a legal document for an Advance Directive. If you have a Living Will, DNR, or Medical PoA you'll need to produce those document to the rescue personnel responding to your emergency. This document is intended for informational purposes only.