EMS*MedFile*

MEDICAL INFORMATION SHEET

POEMSS
Project for Optimal Emergency Medical Services for Seniors

Your Last Name	Your First Name
Your Address	Your Telephone Number Date of Birth: ____________________
Name of Person to Contact in Case of Emergency	Contact Person's Telephone Number
Name of Your Doctor	Your Doctor's Telephone Number
Name of Your Hospital	Hospital Telephone Number
Name of Your Pharmacy	Pharmacy Telephone Number

Medication **ALLERGIES** (List medications you are allergic to here.)

Immunizations:
Pneumovax ____________________ Other(s) ____________________
Influenza ____________________ ____________________
Tetanus ____________________ ____________________

Advance Directive or Living Will completed? ___ Yes or ___ No
Advance Directive Document filed? ___ Yes or ___ No

Document filed where? ____

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MEDICAL INFORMATION SHEET

(Side 2)

Your 'Brief' Medical History (Check "Yes" or "No" as each condition listed does or does not pertain to you.)

Diabetes? ___ Yes or ___ No

____

Heart Disease? ___ Yes or ___ No

Have you ever had a "heart attack?" ___ Yes or ___ No

____

High Blood Pressure? ___ Yes or ___ No

____

Have you ever had a Stroke? ___ Yes or ___ No

____

Seizure Disorder? ___ Yes or ___ No

____

Other? ____

____

Any Special Needs or Disabilities? ______________________________

____