Rootstown Fire Department

Patient Medical History and Information Form

Patient Information

Name	First	Last	
Address	#'s Street	Apt/Rm #	
	City	Zip	
Phone #'s	Home	Cell	
Social Security #		Date of Birth:	
Primary Physician:		Other Physicians:	

Emergency Contact Information

Primary Contact	First	Last	
Relation to Patient:			
Contact Phone #'s	Home	Cell	Work

Secondary Contact	First	Last	
Relation to Patient:			
Contact Phone #'s	Home	Cell	Work

Current Medications

Medication Name	Dose	How Often	Reason for taking

Allergies to Medicines:

Please check any of the listed medical conditions you have:

☐**Cardiac History** ☐**Stroke/TIA's** ☐**COPD** ☐**CHF** ☐**Diabetes**

☐**Asthma** ☐**Seizures** ☐**Infectious Diseases** ☐**Cancer:**_____

Please list any other significant medical conditions on back of page.

Medical History

Please list any pertinent medical history and surgeries below:

YEAR	SIGNIFICANT PROCEDURES/SURGERY/AILMENTS/OR OTHER MEDICAL EVENTS

Special patient notes or instructions:

Preferred Hospital for transport:
Robinson Memorial ☐ Akron City ☐ Akron General ☐ Western Reserve ☐

Do you have a *Do Not Resuscitate* order signed by a physician? YES NO
If so, please provide this in the magnetic pouch also.

Do you have any Medic Alert tags? YES NO
If so please indicate where they are located in the section above.

Do you regularly take any over the counter medications? YES NO
If so, please make sure to list them in the medications section.

By signing below I authorize the Rootstown Fire Department, or anyone responding in their capacity, access and appropriate use of these medical records.

Patients Signature: _____ Date: _____