Patient's Name: ______________________________

Age________ DOB: / / ☐M ☐F ☐Pregnant LMP____

Emergency contact ______________________Cell_____________

History:		
☐Heart disease	☐Asthma, CHF, COPD	☐Diabetes
☐Renal disease	☐Seizures, Epilepsy	☐TIA, Stroke
Other:		

Medication	**Dose**	**Frequency**

Allergies: Place an **X** in the box of all that apply			
☐NKA	☐Food	☐ Insect stings	☐ Latex
☐Drug	☐ Nuts	☐ Penicillin	☐Pollen
Other:			

Coordinates ___________________° N, ___________________° W

First Responder:

Name: ______________________________ Cell: ________________

Chief complaint:

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Pain level, **X** the face that applies.

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