

CITY OF FAIRFAX FIRE 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	Heart Attack/MI
Abnormal EKG/Dysrhythmias	Stent
Angina	Date? _____
Alcohol Consumption	Home Oxygen
Drinks/week	LPM?
Asthma	Hypertension/High BP
Bleeding/Clotting Disorder	Hypotension/ Low BP
Bypass/CABG	Kidney Disease
Blood Thinner	Dialysis? Yes No
Medication?	Pacemaker/ ICD
Cancer	
Where? _____	When? _____

CHF	Smoker
COPD/ Emphysema	Packs/ Day _____
Dementia	Sickle Cell Anemia
Diabetes	Stroke/CVA/TIA
Insulin Dependent	When? _____
Oral Medication	Deficit? _____
Glaucoma	Other: _____

OTHER INFORMATION

Medical Insurance Co.:

Policy #:	Phone #:
Medicare #:	Medicaid #:

Living Will/Advanced Directives on file at:

Health Care Power of Attorney:

Name:	Phone #:
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www.fairfaxva.gov/fire