Bedford Fire Department

Important Patient Information

Name: _____ Age: _____ Sex: _____

Date of Birth: _____ Blood Type: _____ Religion: _____

Address: _____ Phone #: _____

Doctor: _____ Doctors Office: _____

Choice of Hospital (Circle one): Elliot CMC Southern NH St. Joseph

Medical Insurance Company: _____ Policy #: _____ Group#: _____

Important Medical Information

Allergies

- ☐ No Known Drug Allergies
- ☐ Aspirin
- ☐ Insect Stings
- ☐ Latex
- ☐ Morphine
- ☐ Penicillin
- ☐ Sulfa
- ☐ X-Ray Dyes

Others:_____

_____

_____

_____

_____

Medical Conditions & History

- ☐ No Medical History
- ☐ Adrenal Insufficiency
- ☐ Alzheimer's
- ☐ Angina
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer :_____
- ☐ Clotting Disorder
- ☐ Coronary Bypass
- ☐ Dementia
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Leukemia
- ☐ Lymphomas
- ☐ Pacemaker
- ☐ Renal Failure
- ☐ Seizure Disorder
- ☐ Stroke

Others:_____

_____

_____

_____

_____

_____

_____

Medication List

Medication	Dose	Frequency	Medication	Dose	Frequency

☐ DNR or Advance orders must be original and attached to this form to be valid or Located:_____