EMERGENCY PATIENT MEDICAL INFORMATION

YOUR INFORMATION

FIRST AND LAST NAME	DATE OF BIRTH ____/____/________	SOCIAL SECURITY #

ADDRESS	PHONE NUMBER

MEDICAL CONDITIONS *(CHECK OFF AS MANY AS APPLY AND FILL IN BLANKS AS NEEDED)*

- ☐ ATRIAL FIBRILLATION (A-FIB)
- ☐ PACEMAKER / DEFIBRILLATOR
- ☐ HIGH BLOOD PRESSURE
- ☐ CONGESTIVE HEART FAILURE (CHF)
- ☐ COPD / EMPHYSEMA
- ☐ DIABETES
- ☐ CANCER: ____________________
- ☐ ALZHEIMERS / DEMENTIA
- ☐ THYROID CONDITION
- ☐ ASTHMA
- ☐ STROKE
- ☐ OTHER: ____________________

MEDICATIONS:

ON A BLOOD THINNER? WRITE IT BELOW!

ALLERGIES TO DRUGS OR MEDICATIONS

HOSPITAL PREFERENCE:

PREFERRED HOSPITAL NAME

PRIMARY DOCTOR & PHONE NUMBER

DOCTOR NAME	TELEPHONE NUMBER

EMERGENCY CONTACT PERSON:

FIRST AND LAST NAME	RELATION TO YOU	TELEPHONE NUMBER

Upper Perkiomen Valley Ambulance
2199 East Buck Road
Pennsburg, PA 18073

EMERGENCY? Call 9-1-1

Membership questions: 215-679-5989
www.UpperPerkAmbulance.org