



## CURRENT MEDICAL CONDITIONS

(check all that exist)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> No Medical Conditions        | <input type="checkbox"/> Depression       | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Seizure Disorder   |
| <input type="checkbox"/> Abnormal EKG                 | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Laryngectomy          | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Adrenal Insufficiency        | <input type="checkbox"/> Eye Surgery      | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Situs Inversus     |
| <input type="checkbox"/> Alzheimer's                  | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Lymphomas             | <input type="checkbox"/> Stroke or TIA      |
| <input type="checkbox"/> Angina                       | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Malignant Hypothermia | <input type="checkbox"/> Vision Impaired    |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Heart Valve      | <input type="checkbox"/> Memory Impaired       | <input type="checkbox"/> Other:             |
| <input type="checkbox"/> Bleeding Disorder            | <input type="checkbox"/> Hemodialysis     | <input type="checkbox"/> Myasthenia Gravis     | <input type="checkbox"/> Other:             |
| <input type="checkbox"/> Cardiac Dysrhythmia          | <input type="checkbox"/> Hemolytic Anemia | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Other:             |
| <input type="checkbox"/> Coronary Bypass Graft        | <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Renal Failure         | <input type="checkbox"/> Other:             |
| <input type="checkbox"/> Communicable Diseases: _____ |   |  |   |

## ALLERGIES

(check all that exist)

- |                                       |   |                                     |                                       |                                 |
|---------------------------------------|---|-------------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Horse Serum      | <input type="checkbox"/> Lidocaine  | <input type="checkbox"/> Sulfa Drugs  | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Ibuprofen/NSAIDS | <input type="checkbox"/> Morphine   | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Codeine      | <input type="checkbox"/> Insect Stings    | <input type="checkbox"/> Novocaine  | <input type="checkbox"/> X-rays/Dyes  | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Demerol      | <input type="checkbox"/> Latex            | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other:       | <input type="checkbox"/> Other: |

Please list any other important information the Fire Department should know:

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### Instructions:

- This form is provided as a service of Gresham Fire & Emergency Services. In the event of a medical emergency at your home, it is intended to provide our firefighter/paramedics with valuable information concerning your health and past medical history.
- Please complete both sides of this form and post it prominently on the front of your refrigerator.
- Share this form with your health care providers at all visits, to ensure that the information is accurate.
- Update your record when starting or stopping a medication, or when there are changes in your health status.
- Feel free to make copies, or obtain additional forms at your local Gresham Fire Station, or by calling 503-618-2355.