

CURRENT MEDICAL CONDITIONS

(check all that exist)

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

Instructions:

- This form is provided as a service of the Gresham Fire Department. 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.