FAIRFIELD FIRE DEPARTMENT SAFETY SLEEVE PATIENT INFORMATION

NAME	DATE OF BIRTH

PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN PHONE NUMBER

MEDICAL HISTORY (circle all that apply)

Heart attack	High blood pressure	Kidney disease	Asthma	Arthritis
A-fib	Cardiovascular Disease	Diabetes	Bronchitis	Alzheimer's
Stroke	High cholesterol	Cancer	Emphysema	Dementia
Pacemaker	Osteoperosis	Fall risk	COPD	Depression

Other (please list):

MEDICATIONS TAKEN

Medication name	Dose	When do you take this medication?

If you have additional medications, please list on the back of this sheet

WHERE DO YOU KEEP YOUR MEDICATIONS?

ALLERGIES TO MEDICATIONS (please list)

GENERAL ALLERGIES (food, seasonal, environmental)

DO YOU HAVE A "DO NOT RESCUSCITATE" ORDER SIGNED BY A DOCTOR?	Yes	No

IF YOU HAVE A D.N.R., PLEASE PLACE A COPY IN THIS SAFETY SLEEVE

PREFERRED HOSPITALS (in order of preference)

EMERGENCY CONTACT PERSON (NAME)

EMERGENCY CONTACT PERSON PHONE NUMBER

MEDICATIONS TAKEN (Continued from front of sheet)		
Medication name	Dose	When do you take this medication?