MEDIC - PERSONAL INFORMATION

Name

Pronouns

Language

Date of Birth

Phone Number

Emergency Contact Name:

Phone Number

Relationship

ALLERGYS!

SUBSTANCE I'VE USED

NEURODIVERGENT

DISABILITIES

PERSCRIBED MEDICATIONS

INSULIN

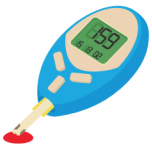
BLOOD THINNERS

INHALER

MENTAL HEALTH

How recently have you taken them?

MEDICAL CONDITIONS



DIABETIES

HYPERTENSTION

SEZIURES

HEART DISEASE

Specific Hospital Needed?

COMMUNICATION & NEEDS

YES

NO

I DON'T KNOW

I can't speak but I can hear you.

MY PHONE

THIRSTY

HUNGRY

BATHROOM

LAY DOWN

HELP

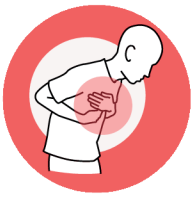
SYMPTOMS

NAUSEA

VOMITING

CAN'T BREATHE

HARD TO BREATHE



CHEST PAIN

DIZZY

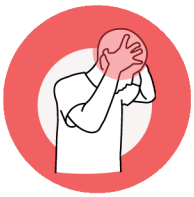
LIKE I WILL FAINT

BODY SHAKY

FEET TINGLE

HANDS TINGLE

ABDOMINAL PAIN



HEAD PAIN

CONFUSION

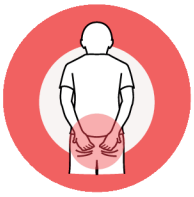
CHANGE IN VISION

BLEEDING

VAGINAL PAIN

STOMACH PAIN

PENIS PAIN



ANAL PAIN

NECK PAIN

SENSATION SCALE / LOCATION

I AM FEELING

PAIN

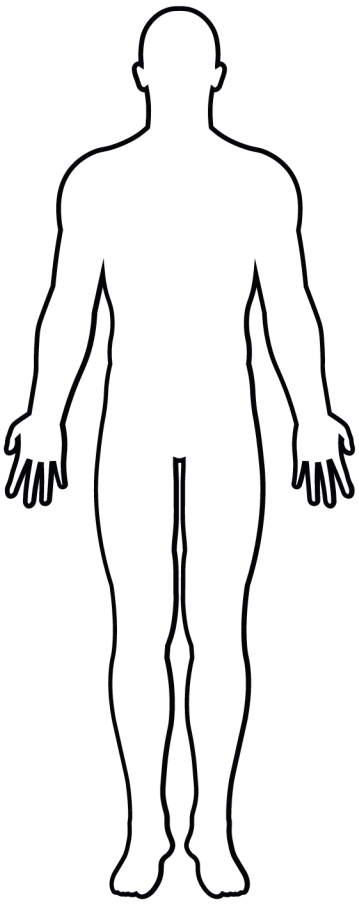
NUMBNESS

TINGLING

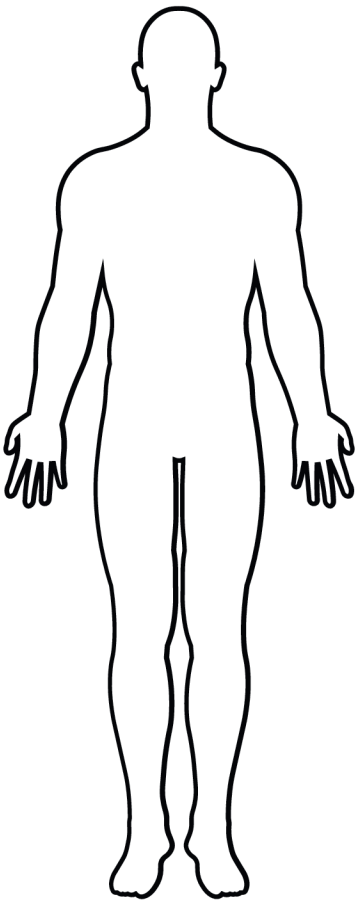
DISCOMFORT

LOCATION & LEVEL

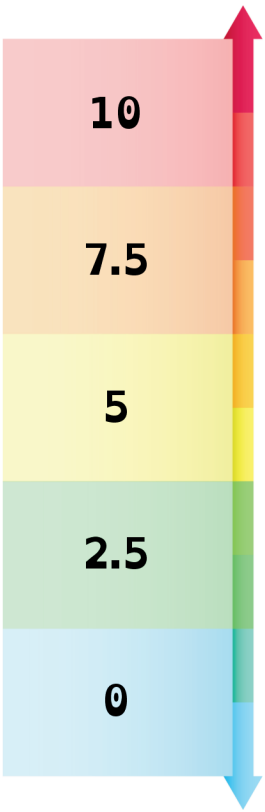
FRONT



BACK



LEVEL



EXTRA DETAILS: