



**City of Peoria Fire Department
Emergency Medical Services**



Medical Information Form

Name _____	Date of Birth _____
Age _____	Phone Number _____
Address _____	
Primary Language _____	Today's Date _____

Emergency Contact _____	Emergency Contact Phone _____
Relationship to Emergency Contact _____	

Hospital Preference _____	
Insurance: _____	I.D. _____ Group _____
Second Insurance: _____	I.D. _____ Group _____

Name of Primary Physician _____	Phone Number _____
Address _____	

Past Medical History (check all medical conditions that exist)			
<input type="checkbox"/> No Medical Condition	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Seizures
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Angina	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> HIV Aids	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other _____