PARAMEDIC ONE-PAGER

Binder of a Lifetime

www.BinderofaLifetime.com

Name: _____ Date of Birth: _____

Street Address, Zip: _____

Home Phone#: _____ Cell Phone#: _____

Gender: ____ Height: _____ Weight: _____ Eye Color: _____ Blood Type: _____

Other Info / Distinguishing Characteristics: _____

Circle/Fill In All That Apply

Heart Attack (year of last): _____	Stroke	Emphysema
Congestive Heart Failure	Angina	Asthma
High Blood Pressure	Diabetes	Bleeding Ulcer
Seizures	Osteoporosis	Bronchitis

Pacemaker Model # _____ Defibrillator Model # _____

Hearing Aid? L R Deaf? L R Vision: Glasses Contact Lenses Artificial Eye? L R

Doctor's Name: _____ Office Phone#: _____

Currently Being Treated For: _____

Current Medications and Dosage: _____

_____

Medication Allergies: _____

Have Living Will? Y N Copy of Living Will at Doctor's Office? Y N

Living Will Primary Contact Name: _____ Phone# : _____

Have Health Care Power of Attorney? Y N Contact Name: _____

Phone#: _____ Second Contact/Phone: _____#:_____

Organ Donor Contact (if applicable): _____

Medical Coverage Medicare/Medicaid #: _____

Other Company Policy Name: _____ Policy #: _____

Emergency Contact

Name: _____ Relationship: _____

Primary Phone#: _____ Cell Phone#: _____

Secondary Contact: _____ Cell Phone#: _____

Religious Contact: _____ Phone#: _____

Use a magnet to place this folded, completed document on your refrigerator

See RESOURCES tab at www.binderofalifetime.com for additional copies or editable forms