PARAMEDIC SERVICES

# FILE OF LIFE

## Patient Medical Information

Name: ______________________________

Last Updated: ___D___/___M___/___Y___

## Personal Information

Full Name: ______________________________
Date of Birth ___D___/___M___/___Y___ Male / Female
Address: ______________________________
City / Town: ______________________________
Province: ______________________________
Postal Code: ______________________________
Health Card Number: ______________________________
Home Phone: ______________________________
Cell Phone: ______________________________
Family Doctor: ______________________________
Office Phone: ______________________________

## Emergency Contact

Full Name: ______________________________
Home Phone: ______________________________
Cell Phone: ______________________________
Relationship: ______________________________

## Existing Medical Problems

*Please describe below*

**Heart**

______________________________

______________________________

**Breathing**

______________________________

______________________________

**Stroke / TIA** (mini stroke)

______________________________

______________________________

**High Blood Pressure**

______________________________

______________________________

**Surgeries**

______________________________

______________________________

**Seizure**

______________________________

______________________________

**Diabetes**

______________________________

______________________________

**Psychiatric**

______________________________

______________________________

**Cancer**

______________________________

______________________________

**Other**

______________________________

______________________________

______________________________

______________________________

______________________________

PARAMEDIC
SERVICES

**Do you have any regular in-home support services?** *Please list below*

______________________________
______________________________
______________________________
______________________________
______________________________

**Allergies

______________________________
______________________________
______________________________

## Current Medications

| Name | Dose | What is the medication for? |
|---|---|---|
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