# When Minutes Count

Sponsored by

Union Ambulance District
www.unionambulancedistrict.org
(636) 583-2600

Union Fire Protection District
www.unionfd.org
(636) 583-2515

| First Name | Middle Name | Last Name | Date of Birth |
|---|---|---|---|
| | | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home Phone Number | Cell Phone Number | Work Phone Number |
|---|---|---|
| | | |

| Social Security Number | Male/Female | Race | Height | Weight | Hair Color | Eye Color | Blood Type | Religion |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

| Hearing Devices: L / R | Deafness: L / R | Unable to Speak ☐ |
|---|---|---|

| Vision: Corrective Lenses / Contacts / Blindness | Other: |
|---|---|

| Dentures: Upper / Lower | Tobacco Use: Yes / No |
|---|---|

Medical Conditions: Please check if you have or have had any of the following:

| | |
|---|---|
| | Diabetes |
| | High Blood Pressure |
| | Heart Attack |
| | Chest Pain / Tightness |
| | Bleeding Problems |
| | Anemia |
| | Abdominal Bleeding |
| | Ulcers |
| | Hepatitis |
| | Stroke |
| | Arthritis |
| | Osteoporosis |
| | HIV |
| | Thyroid |

| | |
|---|---|
| | Cancer |
| | Gallstones |
| | Kidney Stones |
| | Epilepsy / Seizures |
| | Migraine Headaches |
| | Lung Problems / Asthma |
| | Emphysema |
| | Tuberculosis |
| | Glaucoma |
| | Mental Illness |
| | Alcoholism |
| | Drug Addiction |
| | Other: |
| | |

| Pacemaker | Model | Type | Location | Date Implanted |
|---|---|---|---|---|
| | | | | |

| Defibrillator | Model | Type | Location | Date Implanted |
|---|---|---|---|---|
| | | | | |

| Artificial Implants / Devices | Location | Date Implanted |
|---|---|---|
| | | |

| Metal Rod(s) / Plate(s) | Location | Date Implanted |
|---|---|---|
| | | |

| Metal Rod(s) / Plate(s) | Location | Date Implanted |
|---|---|---|
| | | |

| Other | Type / Location(s) | Date Implanted |
|---|---|---|
| | | |

| Other | Type / Location(s) | Date Implanted |
|---|---|---|
| | | |

| Organs Removed / Transplanted | |
|---|---|
| | |

**Emergency Medical Information**

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Drug Inventory Log:

| Date | Drug Name | Dose | Amount Removed / Added | Doctor |
|---|---|---|---|---|
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Allergies: Please List Type and Reaction: None ☐

| Name of Drug / Item | Reaction |
|---|---|
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Names of Doctors:

| Doctors Name | Telephone Number | Date of Last Visit |
|---|---|---|
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| | | |

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| Special Instructions Such as Health Directives, etc. |
|---|
| |
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| |
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Health Insurance Information:

| Primary Insurance Name | | | Phone Number |
|---|---|---|---|
| | | | |
| **Address** | **City** | **State** | **Zip** |
| | | | |
| **Member ID / Policy Number** | **Group Number** | | |
| | | | |
| **Guarantor** | | | **Guarantor's Relationship to Patient** |
| | | | |
| **Address** | **City** | **State** | **Zip** |
| | | | |
| **Home Phone Number** | **Cell Phone Number** | **Work Phone Number** | |
| | | | |
| **Date of Birth** | **Social Security Number** | | |
| | | | |

| Secondary Insurance Name | | | Phone Number |
|---|---|---|---|
| | | | |
| **Address** | **City** | **State** | **Zip** |
| | | | |
| **Member ID / Policy Number** | **Group Number** | | |
| | | | |
| **Guarantor** | | | **Guarantor's Relationship to Patient** |
| | | | |
| **Address** | **City** | **State** | **Zip** |
| | | | |
| **Home Phone Number** | **Cell Phone Number** | **Work Phone Number** | |
| | | | |
| **Date of Birth** | **Social Security Number** | | |
| | | | |

**Please attach copies of any pertinent documentation such as Drivers License, Social Security Card, Insurance Cards, EKG Reading, DNR Forms, POA Forms, etc.**

**Emergency Medical Information**