Please Complete This Form So We Can Help You

Keep this paper with you. A staff person will look at your paper soon.

Patient's name _____

☐ Female ☐ Male

Age _____

Weight _____ kilograms/pounds

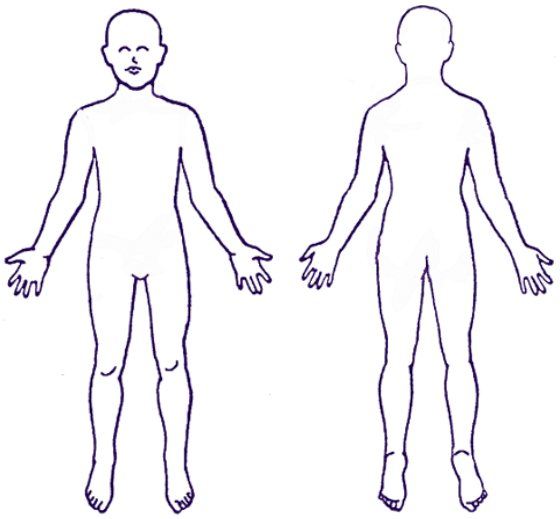
Who is filling out this form?
☐ Me, the patient
☐ Patient's family member or friend
☐ An interpreter for the patient

Why are you here?
☐ I am ill or injured because of a disaster
☐ I am ill or injured but not because of a disaster
☐ I am here to help or look for a family member

Are you pregnant?
☐ Yes
☐ I am in labor
☐ No
☐ I am not sure

What problem are you having? Mark all that apply.
☐ I am having trouble breathing
☐ I am having chest pain, pressure or discomfort
☐ I am bleeding
☐ I have a severe headache
☐ I feel dizzy or lightheaded
☐ I am having problems seeing
☐ I cannot hear
☐ I have a broken bone
☐ My skin is burning
☐ I have a skin rash, swelling or redness
☐ I feel numbness or tingling
☐ I have nausea, vomiting or diarrhea
☐ I have a runny nose, cough or a fever

Mark on these figures where you feel pain.



Mark any diseases or conditions you have or have had in the past.

- ☐ Asthma
- ☐ Diabetes
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Immunosuppression from HIV, cancer or other reason
- ☐ Stroke

Mark any medicines you are taking.

- ☐ Heart medicines
- ☐ Blood pressure medicines
- ☐ Blood thinners such as Coumadin
- ☐ Breathing medicines
- ☐ Insulin
- ☐ Other over the counter medicines such as antacids, laxatives or pain medicines

Mark any allergies you have.

- ☐ Dairy products such as eggs or milk
- ☐ Seafood
- ☐ Dye or iodine
- ☐ Aspirin
- ☐ Penicillin
- ☐ Morphine
- ☐ Sulfa
- ☐ Latex
- ☐ Other _____

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