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
- No
- I am not sure

What problems 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 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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