

# 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** \_\_\_\_\_

Male     Female

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

**Have you traveled outside the country in the past 2 months?**

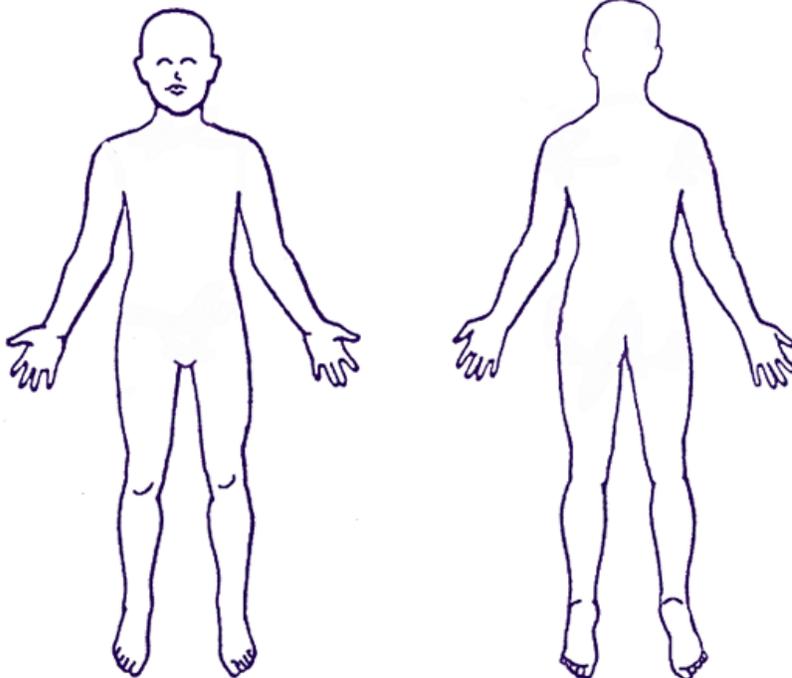
- Yes
- No

If yes, to what country? \_\_\_\_\_

**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 \_\_\_\_\_