



PARAMEDIC SERVICES

FILE OF LIFE

Patient Medical Information Inside



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

