Ottawa Community Paramedicine Program
Programme de Paramédecine Communautaire d'Ottawa

Date Completed: _____

DEMOGRAPHICS

Name:_____ Date of Birth:_____

Address:_____

Telephone:_____ Health Card:_____

Emergency Contact:_____ Telephone:_____

Relationship:_____

Family Doctor:_____ Telephone:_____

MEDICAL HISTORY

☐ Cardiac / Heart (Angina, Heart Attack, Bypass, Pacemaker)		☐ Cancer
☐ Congestive Heart Failure	☐ Asthma	☐ Alzheimer's
☐ Stroke (CVA) or TIA's	☐ Emphysema	☐ Dementia
☐ Diabetes (Insulin / Non-Insulin)	☐ Seizures	☐ Psychiatric
☐ High Blood Pressure (Hypertension)	☐ Hypothyroid	☐ Mental Health
☐ MRSA / VRE / C-Difficile	☐ COPD	☐ _____
☐ _____	☐ _____	☐ _____

MEDICATIONS

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____
7. _____	8. _____	9. _____
10. _____	11. _____	12. _____

ALLERGIES

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____

MAKE COPIES OF THIS FORM AND 1. POST ON YOUR FRIDGE 2. KEEP ONE ON YOUR PERSON 3. GIVE A COPY TO YOUR FAMILY

VITAL SIGNS TREND

Date / Time	GCS	Pulse	Blood Pressure	Respiratory Rate	BGL	SpO2	Temperature

PREVIOUS PARAMEDIC TRANSPORTS

DATE	HOSPITAL	DIAGNOSIS

Additional Information:

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