

# Franklin County Public Safety

## Pre-Hospital Patient Worksheet

Incident #	Date:	AIC:	
Incident location:		Operator:	
Patient Name:		SSN:	Sex:
Address:		Age:	MD:
City:	State:	Zip:	DOB:
Parent/Guardian:			
Fire:		Law:	
Contact Phone #:		Race:	Other:
Allergies:			
Meds:			

### Pre-Existing Conditions

(Check all that Apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Asthma<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Chronic Renal Failure<br><input type="checkbox"/> Chronic Resp. Failure<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Hypertension<br><input type="checkbox"/> Psychiatric Problems<br><input type="checkbox"/> Seizures Disorder<br><input type="checkbox"/> Tracheotomy<br><input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Unknown<br><input type="checkbox"/> Not Applicable<br><input type="checkbox"/> Other: _____<br>_____ |
|---|---|---|

Time	LOC	Pulse	Resp.	BP	Perfusion	Pupils	EKG	Defib	Pulse Ox	Glucose	GCS

Medication	Dose/Route	Time	ID #	Dose/Route	Time	ID #

Drug Box:    Old #: \_\_\_\_\_  
                   New #: \_\_\_\_\_

Remarks: \_\_\_\_\_