



Pre-Hospital Injury/Emergency Form

Patient's Name: _____

Address: _____

Phone #: _____

Age: _____ Date of Birth: _____

Sex: Male Female

Emergency Contact Name / Phone #: _____

SAMPLE HISTORY

Symptoms (What is Wrong?): _____

Allergies: _____

Medications: _____

Past Medical History: _____

Last Meal or Liquid Intake: _____

Events Leading Up to Injury / Illness: _____

Level of Pain: 1 2 3 4 5 6 7 8 9 10
Minor-----Moderate-----Severe

Time of Injury / Illness / Incident: _____

Give Form to Emergency Medical Personnel



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