Date:

EMERGENCY READINESS QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(name surname)*	☐ M ☐ F	**DOB:**
Doctor:	**Last medical exam:**	

GENERAL QUESTIONS		
Do you have a medical emergency card or ID?	☐ Yes	☐ No
Do you always carry a medical emergency card or ID?	☐ Yes	☐ No
Where is your medical emergency card or ID located at this moment?	☐ Yes	☐ No
Who is your immediate contact person in case of an emergency?		
Do you know their phone number by heart?	☐ Yes	☐ No
Who is your alternate contact person in case of an emergency?		
Do you know their phone number by heart?	☐ Yes	☐ No
Do you travel frequently?	☐ Yes	☐ No

PERSONAL HEALTH HISTORY			
Do you have any of the following medical conditions? ☐ Alzheimer ☐ Blood Disorders ☐ Cardiac ☐ Diabetes ☐ Epilepsy ☐ Renal ☐ Other			
Do you have any family history of these medical conditions?	☐ Yes	☐ No	
Do you have any medical implants?	☐ Yes	☐ No	
Do you have any severe allergies?	☐ Yes	☐ No	
Do you take any of the following medicines?			
☐ Anticoagulants ☐ Chemotherapy ☐ Epinephrine auto injector ☐ Immunosuppressant ☐ Insulin ☐ Other			