vial of L.I.F.E.©

Medical Information

Name: ______________________________ Date: ______________

Address: ____

Home Phone: ______________ Lives With: ______________________

Date of Birth: _____ - ____ - ______ Blood Type: ________ Eye Color: ____________

Height: __________ Weight: ______________ Sex: ________

Medicare Number: ______________ Other Insurance: ________________

Hospital Preference: ______________ Primary Language: ________________

Physician: __________________________ Phone: ______________

Physician: __________________________ Phone: ______________

Emergency Contacts:

Name	Name
Phone	Phone
Cell Phone	Cell Phone
Address	Address
Relationship	Relationship

I have the following Advanced Directive: (If you want these wishes followed, enclose a copy in this vial.)

☐Durable Power of Attorney for Health Care

☐Pre-Hospital Do Not Resuscitate

MEDICAL CONDITIONS (*check all that exist*)

☐No medical conditions
☐Angina
☐Heart Attack
☐HIV / AIDS
☐Hepatitis
☐Fractures
☐COPD / Emphysema
☐High Blood Pressure
☐Cancer (Type)________________________________
☐Pacemaker
☐Stroke
☐Asthma
☐Diabetes/Hypoglycemia
☐Seizures
☐Bleeding/Clotting Disorder
☐Kidney Problems
☐Other

Contact Lens ☐Yes ☐No

ALLERGIES (*check all that exist*)

☐No known allergies
☐Latex
☐Demerol
☐Codeine
☐Morphine
☐Insect Stings
☐Penicillin
☐Aspirin
☐Sulfa
☐Other ______________________

MEDICATIONS

Name	Dosage	Frequency