

vial of L.I.F.E. ©

Medical Information Form

Date: _____

Name: _____

Address: _____

Home Phone: _____

Lives With: _____

Date of Birth: _____ - _____ - _____

Eye Color: _____ Hair Color: _____ Sex: M / F

Height: _____ Weight: _____

Medicare #: _____

Other Insurance: _____

Hospital Preference: _____

Primary Language: _____

Physician: _____ Phone: _____

Physician: _____ Phone: _____

Emergency Contact:

Name: _____

Phone: _____

Address: _____

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) _____
- Other _____
- Pacemaker
- Stroke
- Asthma
- Diabetes/Hypoglycemia
- Seizures
- Bleeding/Clotting Disorder
- Kidney Problems

Contact Lens Yes No

ALLERGIES (check all that exist)

- No known allergies
- Latex
- Demerol
- Codeine
- Morphine
- Other _____
- Insect Stings
- Penicillin
- Aspirin
- Sulfa

CURRENT MEDICATIONS as of - date: _____

(example: Lasix 20 Mg. 1 tablet 2x Day)
