FILE OF LIFE

Use a pencil to allow for easy updates,
OR complete online & print.

KEEP INFORMATION UP TO DATE!

Review at least every six months.
Last Updated: _____

MEDICAL DATA

Special Conditions/Remarks:

Medication	Dosage	Frequency

MEDICAL CONDITIONS

Check all that apply

	None known		Hemodialysis
	Abnormal EKG		Hemolytic Anemia
	Adrenal Insufficiency		Hepatitis Type
	Angina		HIV Positive
	Asthma		Hypertension
	Bleeding Disorder		Hypoglycemia
	Cancer		Laryngectomy
	Cardiac Dysrhythmia		Leukemia
	Cataracts		Lymphomas
	Clotting Disorder		Memory Impaired
	Coronary Bypass Graft		Myasthenia Gravis
	Dementia		Pacemaker
	Alzheimer's		Renal Failure
	Diabetes/Insulin Dependent		Seizure Disorder
	Eye Surgery		Sickle Cell Anemia
	Glaucoma		Stroke
	Hearing Impaired		Tuberculosis
	Heart Valve Prosthesis		Vision Impaired
	OTHER:		

ALLERGIES

	Aspirin		Insect Stings		Penicillin
	Barbiturate		Latex		Sulfa
	Codeine		Lidocaine		Tetracycline
	Demerol		Morphine		X-ray dyes
	Horse Serum		Novocain		None known

Environmental/Other:

Name:

Address:

Date of Birth:

Sex: _ Male _ Female _ Other/Decline

Primary Care Doctor:

Phone #:

Preferred Pharmacy:

MEDICAL INSURANCE

Phone#:

Medical Insurance Co:

Policy #:

Other Medical Insurance:

Policy #:

_ Medicare - Policy #:

_ Medicaid/Medi-Cal - Policy #:

Health Care Power of Attorney (POA)	_ Yes	No

EMERGENCY CONTACTS

#1 Contact Name:

Address:

Phone #:

#2 Contact Name:

Address:

Phone #:

Recent Surgeries (List Below):	Surgery Date(s):

Do you have an EMS- NO CPR Directive or DNR Form?
_ Yes No

If yes, where is it located? _____

Other Special Conditions or Considerations:

Blood Type:

Donor: Yes _ No

Health Care Proxy: _ Yes _ No
(if yes) On file at:

Living Will: _ Yes _ No
(if yes) On file at:_____

Religious Preference: