VIAL OF LIFE

EMERGENCY MEDICAL INFORMATION

Please check and update this form monthly for accuracy!

Date Completed: _____ **Updated:**_____ _____ _____ _____ _____ _____ _____

Basic Information

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____

In Case of Emergency, Please Notify: _____

Phone: _____ Relationship: _____

Street: _____ City: _____ State:_____

Identifying Information

_____ Male _____ Female Height: _____ Weight: _____

Date of Birth: _____Marital Status: _____

Hair Color: _____ Eye Color: _____

Blood Type: _____ Religion: _____

Primary Language Spoken: _____Other Language(s):_____

_____ Glasses _____ Contact Lenses _____ False Teeth/Bridge

Hearing Aid: _____ Left _____ Right Deaf: _____ Left _____ Right

Blind: _____ Left _____ Right Artificial Eye: _____ Left _____ Right

Artificial Limbs or Prosthetic Devices: _____

Pacemaker Model #:_____ Defibrillator Model #: _____

Identifying Marks (i.e., birthmarks, tattoos, etc.): _____

Normal Blood Pressure: _____/_____ _____ Smoker _____Non-Smoker

Medical History

Check Conditions that you have been treated for:

☐ Allergies	☐ Blood Pressure	☐ Epilepsy	☐ Heart Condition	☐ Tuberculosis
☐ Anemia	☐ Cancer	☐ Glaucoma	☐ Jaundice	☐
☐ Arthritis	☐ Diabetes	☐ Hay Fever	☐ Sinus	☐
☐ Asthma	☐ Insulin	☐ Hepatitis	☐ Stroke	☐

Be sure to complete reverse side →

Current Medical Information

Name of Doctor: _____ Phone #: _____

Name of Doctor: _____ Phone #: _____

Currently Being Treated For:

_____

_____

*Current Medications:

Medication	Dosage	Taken How Often? (Frequency)	Taken to treat what condition?	Located where in your home?

*Attach & date a separate page for additional medications or to record updates.

Allergies to Medications: _____

_____

Hospital Information

Hospital Preference:_____ City_____ State _____

Last Hospitalization: _____

Hospital: _____ Date:_____ Treated For: _____

_____ Living Will If yes, location of Living Will: _____

_____ Do Not Resuscitate (DNR) Order Location of DNR: _____

_____ Organ Donor

Medical Insurance Coverage

Medicare #: _____ Medicaid #: _____

Blue Cross/Blue Shield #: _____

Other Policy #: _____

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