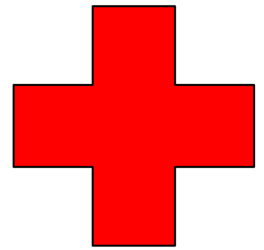
VIAL OF LIFE

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 Order Location of DNR: ____________________________________

_____ Organ Donor

Medical Insurance Coverage

Medicare #:__________________________ Medicaid #:__________________________

Blue Cross/Blue Shield #: ________________________________

Other Policy #:____

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