
**FILE OF LIFE**

MEDICAL DATA LAST REVIEWED ON

Month_____ Year _____

**Do Not Resuscitate Order: Yes ☐ No ☐**

**Advance Directive: Yes ☐ No ☐**

Name:

Male ☐ Female ☐

House #: Street:

Doctor: Phone:

Preferred Hospital: 0

## EMERGENCY CONTACTS

Name: Phone:

Address:

Name: Phone:

Address:

## MEDICAL INFORMATION

Special Conditions/Remarks:

| Medication | Dosage | Frequency |
|---|---|---|
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Pharmacy: Phone:

Date of Birth:

Blood Type: Religion:

Health Care Proxy on file at:

Living Will on file at:

Recent Surgery: Date:

If you have an EMS-NO CPR Directive or a DNR form, where is it located?

## MEDICAL CONDITIONS

(Check all that exist)

- ☐ No known Medical Conditions
- ☐ Abnormal EKG
- ☐ Adrenal Insufficiency
- ☐ Angina
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Cardiac Dysrhythmia
- ☐ Cataracts
- ☐ Clotting Disorder
- ☐ Coronary Bypass Graft
- ☐ Dementia ☐ Alzheimer's
- ☐ Diabetes/Insulin Dependent
- ☐ Eye Surgery
- ☐ Glaucoma
- ☐ Hearing Impaired
- ☐ Heart Valve Prosthesis
- ☐ Other:
- ☐ Hemodialysis
- ☐ Hemolytic Anemia
- ☐ Hepatitis-Type___
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Laryngectomy
- ☐ Leukemia
- ☐ Lymphomas
- ☐ Memory Impaired
- ☐ Myasthenia Gravis
- ☐ Pacemaker
- ☐ Renal Failure
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vision Impaired

## ALLERGIES

- ☐ Aspirin
- ☐ Barbiturate
- ☐ Codeine
- ☐ Demerol
- ☐ Horse Serum
- ☐ Insect Stings
- ☐ Latex
- ☐ Lidocaine
- ☐ Morphine
- ☐ Novacaine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ X-Ray Dyes
- ☐ No Known
- ☐ Environmental:
- ☐ Other:

## MEDICAL INSURANCE

Med Ins Co:

Policy #:

Other Med Ins Co:

Policy #:

Medicaid #: Medicare #: