VIAL OF LIFE INFORMATION

Date Info Entered _____/_____/_____

Name:______________________________

Birth Date _____/_____/_____

Sex: Male____ Female____

Ambulatory ____Non-Ambulatory ____

PRIMARY PHYSICIAN:

Name:_____________________________

Phone: (_____)____________________

OTHER KEY PHYSICIAN:

Name:_____________________________

Phone:(_____)______________________

NAME OF INSURANCE:

Primary____________________________

Secondary:_________________________

IN CASE OF EMERGENCY CONTACT:

1.Name____________________________

Relationship_______________________

Home Phone________________________

Cell Phone_________________________

Work Phone________________________

2.Name ___________________________

Relationship_______________________

Home Phone________________________

Cell Phone_________________________

Work Phone________________________

Optional

Attach your photo here

MEDICAL PROBLEMS

Please check if you have any of the following:

___Emphysema/COPD

___Congestive Heart Failure

___History of Heart Attack

___ Pacemaker

___High Blood Pressure

___Irregular Heart Beat

___Stroke (left___ right___)

___Diabetes (insulin___ oral/diet___)

___Parkinson's Disease

___Epileptic Seizure

___Deaf/hearing impaired

___Blind/Visually Impaired ___

___Glaucoma

___AIDS/HIV

___Dementia

___Cancer

___Hepatitis

___Asthma

___Arthritis

Other:

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____

MEDICATION ALLERGIES (with Reaction):

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SURGICAL HISTORY: include eye & dental, list month & year, especially if recent.

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PRESCRIBED MEDICATIONS

List the name of each drug, strength, dosage, where kept. Also list vitamin/mineral supplements & over the counter medications. Use back of form if needed.

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The above information will be utilized in accordance with state and federal privacy laws.