



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:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Jaundice	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Sinus	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Insulin	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke	<input type="checkbox"/>

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 #: _____