FILE OF LIFE

Personal Information

Name:_____ **Gender:**_____ **DOB:**_____

Address:_____

Home Phone:_____ **Cell Phone:**_____

Emergency Contacts

Name:_____ **Relationship:**_____

Home Phone:_____ **Cell Phone:** _____

Name:_____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

Doctor:_____ **Doctor Phone:** _____

Medications

Medication	Dosage	Frequency

Are you on any blood thinner medication? ☐ Yes (listed above) ☐ No

Surgeries Within 1 Year

Date	Type

Medical Conditions

- ☐ No known conditions
- ☐ Abnormal EKG
- ☐ Adrenal insufficiency
- ☐ Alzheimer's
- ☐ Angina
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Myasthenia gravis
- ☐ Clotting disorder
- ☐ Coronary bypass graft
- ☐ Dementia
- ☐ Diabetes/Insulin dependent
- ☐ Eye surgery
- ☐ Glaucoma
- ☐ Hearing impaired
- ☐ Heart Valve Prosthesis
- ☐ Other: _____

_____

- ☐ Hemodialysis
- ☐ Hemolytic anemia
- ☐ Hepatitis - Type:_____
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Leukemia
- ☐ Lymphomas
- ☐ Memory impaired
- ☐ Pacemaker
- ☐ Renal failure
- ☐ Seizure disorder
- ☐ Sickle cell anemia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vision impaired

Allergies

- ☐ No known allergies
- ☐ Aspirin
- ☐ Barbiturate
- ☐ Codeine
- ☐ Demerol
- ☐ Horse Serum
- ☐ Insect stings
- ☐ Latex
- ☐ Lidocaine
- ☐ Morphine
- ☐ Novocaine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ X-Ray dyes
- ☐ Other: _____

_____

Other Information

Medical Insurance Company:_____ **Policy #:**_____

Health care proxy, living will, Do Not Resuscitate order? ☐ Yes ☐ No

Where are they located?_____

Hospice Care? ☐ Yes ☐ No **Provider:** _____

This File Of Life was created on:_____