VIAL OF L.I.F.E.—MEDICAL INFORMATION

Date:			
Name:			
Street Address:			
City:		State:	Zip:
Home Phone#:			
Lives With:			
Date of Birth:		Eye Color:	Blood Type:
Hair Color:	Sex:	Weight:	Height:
Medicare #:			
Other Insurance:			
Hospital Preference:			
Primary Language:			
Physician:		Phone #:	
Physician:		Phone #:	
	EMERGENCY CONTACTS:		
Name:		Phone #:	Cell #:
Street Address			
City:	State:	Zip:	
Relationship:			
Name:		Phone #:	Cell #:
Street Address			
City:	State:	Zip:	
Relationship:			

I have the following Advance Directive: (If you want these wishes followed, enclose a copy in this vial.)

☐ *Durable Power of Attorney for Health Care*

☐ *Pre-Hospital Do Not Resuscitate*

***MEDICAL CONDITIONS** (check all that exist)*

◯ *No medical conditions*
☐ *Angina*
☐ *Heart Attack*
☐ *HIV / AIDS*
☐ *Hepatitis*
☐ *Fractures*
☐ *COPD / Emphysema*
☐ *High Blood Pressure*
☐ *Cancer (Type)* ______
☐ *Pacemaker*
☐ *Stroke*
☐ *Asthma*
☐ *Diabetes/Hypoglycemia*
☐ *Seizures*
☐ *Bleeding/Clotting Disorder*
☐ *Kidney Problems*
☐ *Other* ______

Contact Lens ☐ *Yes* ☐ *No*

***ALLERGIES** (check all the apply)*

◯ No known allergies
☐ Latex
☐ Demerol
☐ Codeine
☐ Morphine
☐ Insect Stings
☐ Penicillin
☐ Aspirin
☐ Sulfa
☐ Other ______

CURRENT MEDICIATIONS As of – Date:

Name of Prescription:	Dosage

Please use the reverse side for additional information on your medical history.

Information you may want to include:

- Identifying marks
- Past Medical History
- Current Medical Condition
- Last Hospitalization
- Dentures
- Hearing/Vision problems

Additional medical information: ______________________________________
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Additional medical information: ______________________________________
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