VIAL OF LIFE

(Please use a separate form for each person)

Last Name ____________ First Name ____________ Middle ______ Birth Date & Year ____________ Sex ______

Street Address ____________ City ____________ Zip Code ______ Telephone # with area code ____________

SSN# ____________ Medicare # ____________ Other Insurance ____________

Eye Color ______ Hair Color ______ Height ______ Weight ______ Identifying Marks: ____________

Heart Problem ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
Respiratory Problems ☐ Yes ☐ No
Hearing Aids ☐ Yes ☐ No
I have a living will ☐ Yes ☐ No

Pace Maker ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Dentures ☐ Yes ☐ No
Glasses ☐ Yes ☐ No
Blood Type (If Known) ____________

Medical History:

____
____
____

Allergies:

____
____

Additional Medical Problems:

____
____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING OVER THE COUNTER AND THE REASON FOR TAKING THEM.

MEDICATION NAME	PURPOSE	MEDICATION NAME	PURPOSE

IN CASE OF EMERGENCY, PLEASE NOTIFY:

(Please list in order of importance)

1. ____________ Name ____________ Telephone # with area code ____________ Relationship
2. ____________ Name ____________ Telephone # with area code ____________ Relationship
3. ____________ Name ____________ Telephone # with area code ____________ Relationship

Physician's Name ____________ Physician's Phone Number ____________ Preferred Hospital ____________