



VIAL OF L.I.F.E.

Life Saving Information For Emergencies

I certify that the information on this form is accurate and up-to-date. I also understand that emergency medical personnel may rely on this information and I agree not to hold emergency personnel responsible for inaccurate or out of date information.

DATE COMPLETED: _____ **SIGNATURE:** _____

PATIENT INFORMATION:

Name:	Date of Birth:
Address:	Sex: Male: Female:
City:	State: Zip Code:
Social Security No:	Phone: ()

Primary Medical Problems:	
Doctor's Name:	Doctor's Phone::
Hospital Preference:	Have you been a patient there? Yes No
Medicare #:	Medical #:
Other Health Insurance:	Health Insurance #:

HEALTH INFORMATION:

Allergies to medication::
Other allergies:
Current Medications: (Name/Dose)
Do you have a pacemaker? Yes No Model #: Blood Type:
Do you have a directive? Yes No Where is it?

PREVIOUS MEDICAL PROBLEMS: (Check all that apply)

<input type="checkbox"/> Heart	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Stroke	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Seizures	<input type="checkbox"/> Emphysema	<input type="checkbox"/> AIDS	<input type="checkbox"/> Anemia
<input type="checkbox"/> Cancer	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Others: _____			

EMERGENCY REFERENCES:

Name:	Phone:
Address:	Relation:
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Address:	Relation:

