File of Life

General Information Effective Date: _____

Name: _____ _____

Address: _____

City, State: _____ Zip Code: _____

Phone (Home) : _____ (Cellular) : _____

DOB: __ __ /__ __/__ __ Gender: M F Height: _____ Weight: _____ Marital Status: S M W D

Health Insurance Information

Social Security No. (last 4 digits):__ __ __ __ Medicare Number: _____

Primary Insurance Company: _____ Policy Number: _____

Secondary Insurance Company: _____ Policy Number: _____

Have you filled out an Advance Directive for Health Care Form? Y N

If yes, name of health care agent: _____ Phone: _____

Have you requested a Do Not Resuscitate order? Y N If Yes, please enclose/attach.

Notify in Case of Emergency

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Others Living in the Home

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Pet Name/Type _____ Pet Sitter Name: _____ Phone: _____

Medical Information

Primary Physician: _____ Phone: _____

Secondary Physician: _____ Phone: _____

Specialty Physician: _____ Phone: _____

Location of Hospital Records: _____

Normal Blood Pressure: _____

Drug Allergies (specify): _____

Food Allergies (specify): _____

File of Life

Medical Information - continued

What medical problems/physical disabilities do you have? _____

_____

_____

List past surgeries (type and date): _____

_____

_____

_____

_____

Do you:

Wear dentures? Y N Wear glasses? Y N Wear contacts? Y N Wear a hearing aid? Y N

Use oxygen? Y N

Where do you keep your medications? _____

Current Medications (list prescription, over the counter drugs, vitamins, herbal supplements, eye drops, etc.)

Name: _____ Dosage: _____ Times: _____

Name: _____ Dosage: _____ Times: _____

Name: _____ Dosage: _____ Times: _____

Name: _____ Dosage: _____ Times: _____

Name: _____ Dosage: _____ Times: _____

Name: _____ Dosage: _____ Times: _____

Name: _____ Dosage: _____ Times: _____

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