VIAL OF LIFE FORM

General Information

Name: ____ Date: ____________

Address: _____________________________________ Phone: __________________

City, State: ____ Zip Code: __________

Date of Birth: __ __ /__ __/__ __ Gender: Male ___ Female____

Height: ____ Weight: ____ Marital Status: Single___ Married___ Widowed____ Divorced____

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? Yes___ No___

If yes, name of health care agent: _________________________ Phone: ________________

Have you requested a Do Not Resuscitate order? Yes__ No __ If Yes, enclose/attach.

Notify in Case of Emergency

Name: ______________________ Relationship: ____________ Phone: ______________

Name: ______________________ Relationship: ____________ Phone: ______________

Name: ______________________ Relationship: ____________ Phone: ______________

Others Living in the Home

Name: ______________________ Relationship: ____________ Phone: ______________

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): ____

What medical problems/physical disabilities do you have? _______________________________

____

List past surgeries (type and date): ____

____

VIAL OF LIFE FORM

Do you:

wear dentures? Yes___ No___ wear glasses? Yes___ No___

wear contacts? Yes___ No___ wear a hearing aid? Yes___ No___

use oxygen? Yes___ No___

Where do you keep your medications? ____

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

Name: ____________________________ Dosage: _______________ Times: _________________

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Name: ____________________________ Dosage: _______________ Times: _________________

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