BOTTLE OF LIFE

MEDICAL INFORMATION FOR LIFE SAVING EMERGENCIES

Date Completed:

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ State _____ Zip Code _____

Telephone Number _____

Date of Birth	Male/Female	Height	Weight	Hair Color	Eye Color	Blood Type

Unable to Speak ☐ | Dentures: ☐ Upper ☐ Lower | Pacemaker: ☐ Yes ☐ No

Native language if not English: _____ Religion: _____

List hearing difficulties: _____ List vision difficulties: _____

Identifying Marks:

Patient Medical Information

Current medical conditions: _____

Past medical conditions/surgeries: _____

Current medications including dosage and times: _____

Allergies to medications: _____

Last hospitalization: _____

Special instructions such as health directives, or DO NOT Resuscitate orders, etc.: _____

Doctor's Name: _____ Telephone No: _____

Health Insurance Policy:

Emergency Contact Information

Name: _____ Relationship: _____

Telephone No. 1: _____ Telephone No. 2: _____

Name: _____ Relationship: _____

Telephone No. 1: _____ Telephone No. 2: _____

Name: _____ Relationship: _____

Telephone No. 1: _____ Telephone No. 2: _____

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