FILE OF LIFE

Person #1

Date _____

Name _____

Address _____

Phone _____

Date of Birth M/Y _____

Height _____ Weight _____ Hair color _____

Sex M F Blind Left Right

Glasses Yes No Contacts Yes No

Dentures Yes No Mute Yes No

Hearing Aids Yes No Deaf Yes No

Native Language _____

Religion _____

Social Security XXX-XX- _____ last 4 digits only

Doctor's Name _____

Doctor's Phone _____

Hospital Preference _____

In Case of Emergency Notify

Name _____

Address _____

Phone _____ Relation _____

Insurance Coverage

Medicare # _____ last 4 digits only

Medicaid # last 4 digits only

Other (Name) _____

Health Information _____

Allergies to medication _____

Current Medications _____

_____

_____

Pharmacy _____

Do you have a pace maker? Yes No

Are you an Organ Donor? Yes No

Do you have a health care surrogate? Yes No

Name_____ Phone _____

Do you have a Living Will? Yes No

Do you have a "Do Not Resuscitate Order"? Yes No

HAVE YOU EVER BEEN TREATED FOR

AIDS---Yes No	Anemia Yes No
Arthritis Yes No	Cancer Yes No
Dementia Yes No	Dialysis Yes No
Diabetes Yes No	Epilepsy Yes No
Glaucoma Yes No	Heart Condition Yes No
Hepatitis Yes No	High Blood Pressure Yes No
Respiratory Yes No	Stroke Yes No
Sickle Cell Yes No	Tuberculosis Yes No

Other (specify)_____

ATTACH COMMENTS ON SEPARATE SHEET