FILE OF LIFE

Please update after every doctor's appointment

Name: Gender: M F

Date of Birth:

Address 1:

Address 2:

Preferred Hospital:

Primary Doctor:

Emergency Contacts / Power of Attorney

Name:

Phone #: Relation:

Name:

Phone #: Relation:

MEDICAL HISTORY

- ☐ No Known Medical Problems
- ☐ Abnormal EKG
- ☐ Adrenal Insufficiency
- ☐ Angina
- ☐ Asthma
- ☐ Bleeding/ Clotting Disorders
- ☐ Cancer: _____
- ☐ Cardiac Arrhythmia
- ☐ Cataracts
- ☐ Coronary Bypass Graft
- ☐ Dementia
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Hearing Impaired
- ☐ Heart Valve Prosthesis
- ☐ Hemodialysis
- ☐ Hemolytic Anemia
- ☐ Hepatitis A B C
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Laryngectomy
- ☐ Leukemia
- ☐ Lymphomas
- ☐ Memory Impaired
- ☐ Myasthenia Gravis
- ☐ Pacemaker
- ☐ Seizure Disorder
- ☐ Renal Failure
- ☐ Sickle Cell Anemia
- ☐ Stroke [R L Impaired]

Other: _____

_____

MEDICATIONS

Updated as of: / /

Medications	Dosage	Frequency

Pharmacy:

Religion:

Will on file at:

Health Care Proxy:

Do you have a: Do Not Resuscitate (DNR), Advanced Directives, or NO-CPR order? YES NO

Location of paperwork:

ALLERGIES

☐ **YES** - List all allergies: _____

_____

_____

☐ NO Known Drug Allergies

MEDICAL INSURANCE

Primary Insurance: _____
Group / Policy: _____

Secondary Insurance: _____
Group / Policy: _____

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