THE FILE OF LIFE

Review at least every six months! MEDICAL DATA REVIEWED AS OF MO. YR.

Name:_____ Gender: F or M

Address:_____ DOB:_____

Preferred Hospital:_____

EMERGENCY CONTACTS

Name:_____ Phone #:_____

Address:_____

Name:_____ Phone #:_____

Address:_____

MEDICAL DATA

Past Medical History:_____

_____

Current Medical Issues:_____

_____

Current Medications:_____

_____

Allergies:_____

Blood Type:_____

Health Care Proxy:_____

Living Will:_____

Do you have a DNR?:_____

Other pertinent information:_____

_____