FILE OF LIFE FORM

Complete form and review at least every six months. In an emergency, call 911.

DOING WHAT'S BEST.

This medical data was reviewed as of / /

Use a pencil when filling out.

Name

Sex: Male Female

Phone ( )

Address

Date of Birth / /

Height

Weight

Primary Language

Religion

Blood Type

Doctor and Phone # ( )

Doctor and Phone # ( )

Emergency Contacts

Name and Phone # ( )

Name and Phone # ( )

Address

Address

Medications

	Medication Name	Reason Taking	Dosage	Frequency
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Known Allergies

Do you have a Do Not Resuscitate (DNR) order signed by a doctor? No Yes

If so, where is it located?

Medical Condition(s)

Angina	Cardiac Dysrhythmia:	Coronary Bypass Graft	Hemodialysis	Psychiatric Issues:
Asthma	________________	Dementia / Alzheimer's	Hypertension	________________
Bleeding Disorder	CHF	Diabetes	Hypoglycemia	Seizure Disorder
Cancer: __________	COPD	Hearing Impaired	Pacemaker	Stroke

Other

Medical Insurance & Legal Documents

Medical Insurance or Medicare Supplement Insurance

Policy #

Medicare Policy #

Medicaid Policy #

Other information you wish medical professionals to know