VIAL OF LIFE

HEALTH INFORMATION SHEET

NAME ________________________________ PHONE (   ) ______________________

ADDRESS __________________________________ CITY _________________________

BIRTHDATE ______________________ MALE ☐ FEMALE ☐

DATE FORM COMPLETED ____

PHYSICIAN'S NAME _______________________ PHONE (   ) ____________________

HOSPITAL OF CHOICE ____

INSURANCE INFORMATION ____

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CHURCH _______________________________ PHONE (   ) ______________________

MEDICATION	DOSAGE	TIMES

ALLERGIES (MEDICATION, FOOD, ETC.) ____________________________________

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EMERGENCY CONTACT PERSON ____

ADDRESS __________________ CITY _______________ ST ______ ZIP ________

WORK PHONE ( ) ________ HOME PHONE ( ) ______ RELATIONSHIP _______

EMERGENCY CONTACT PERSON ____

ADDRESS __________________ CITY _______________ ST ______ ZIP ________

WORK PHONE ( ) ________ HOME PHONE ( ) ______ RELATIONSHIP _______

I have a DNR "Do Not Resuscitate" ☐ YES (Attach copy of DNR) ☐ NO

I have a Living Will ☐ YES (Attach copy of Living Will) ☐ NO

I am an organ donor ☐ YES ☐ NO

I have a durable power of attorney for health care decisions ☐ YES ☐ NO
(Attach copy of durable power of attorney)

Personal Medical History: This should include conditions such as diabetes, congestive heart failure, irregular heartbeat, emphysema, asthma, lung problems, heart attach or others. If you have had surgery, list when, where and what type. If you have a current history and physical, please attach to this form.

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FAMILY HISTORY: (PLEASE CHECK ALL THAT APPLY)

☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ Asthma

☐ Hypertension (High Blood Pressure) ☐ Lung Disease ☐ Thyroid

☐ Blood Clots ☐ Other (Please List) ___________________________

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