Medical File of Life

{this form is available at the Town Office}

Name: Sex: M / F
Address:
Date of Birth:

EMERGENCY CONTACTS

Name #1: Home Phone:
Address:
Relation: Work Phone:

Name #2: Home Phone:
Address:
Relation: Work Phone:

MEDICAL DATA

Last Updated: Month Year: Blood Type:
Doctor: Hospital: Phone Number:
Doctor: Hospital: Phone Number:

Special Conditions / Remarks: _____

_____

_____

Medical Problems: Medication: Dosage: Frequency:

Recent Surgery: Date:

Religion:
Living Will on file at:
Health Care Proxy on file at:

Do you have an EMS-NO CPR Directive or a DNR Form?

YES ____ NO _____

MEDICAL CONDITIONS

Check all that exist

___ No known medical conditions

___Abnormal EKG

___Adrenal Insufficiency

___Angina

___Asthma

___Bleeding Disorder

___Cancer

___Cardiac Dysrhythmia

___Cataracts

___Clotting Disorder

____Hemodialysis

____Hemolytic-Anemia

____Hepatitis Type ( )

____Hypertension

____Hypoglycemia

____Laryngectomy

____Leukemia

____Lymphomas

____Memory Impaired

____Myasthenia Gravis

___Coronary Bybass Graft ____Pacemaker

___Demential /Alzheimer's ____ ____Renal Failure

___Diabetes / Insulin Dependent ____Seizure Disorder

___Eye Surgery ____Sickle Cell Anemia

___Glaucoma ____Stroke

___Hearing Impaired ____Tuberculosis

___Heart Valve Prosthesis ____Vision Impaired

___Other:_____

ALLERGIES

___Aspirin ___Insect Stings ____Penicillin ____Food Allergies

___Barbiturate ___Latex ____Sulfa ____Seafood

___Codeine ___Lidocaine ____Tetracycline ____Peanuts/Nuts

___Demerol ___Morphine ____X-Rays Dyes

___Horse Serum ___Novacaine ____No Known Allergies

___Environmental: _____

___Other:_____

MEDICAL INSURANCE

Medical Insurance Company:_____ Phone #:_____

Policy #:_____

Medicare / Medicaid #: _____ Other Insurance:_____