File of Life

Keep your information up to date.
It's recommended to review at least once every six months.

Name: _____

Male Female Date of Birth: _____ Form Updated: ____/____

Home Address: _____

Do you have an EMS-NO CPR Directive or DNR form? Yes No
If yes, where is it located? _____

Emergency Contacts:

Name and Relationship ***Phone Number***

1. _____
2. _____
3. _____

Primary Care Doctor: _____

Preferred Hospital: _____ Blood Type: _____

Use Pencil for Ease in Making Changes

Special Conditions: _____
_____

Recent Surgeries and Dates: _____
_____

Allergies:

□ No Known Allergies	□ Aspirin	□ Penicillin
□ Barbiturate	□ Latex	□ Sulfa
□ Codeine	□ Lidocaine	□ Tetracycline
□ Demerol	□ Morphine	□ X-Ray Dyes
□ Horse Serum	□ Novocaine	□ Insect Stings
□ Environmental	□ Other: _____	□ Other: _____

Medication	*Dose*	*Frequency*

Medical Conditions:

Check all that apply

□ No known medical conditions
□ Abnormal EKG
□ Adrenal Insufficiency
□ Angina
□ Asthma
□ Bleeding Disorder
□ Cancer (Type: _____)
□ Cardiac Dysrhythmias
□ Cataracts
□ Clotting Disorder
□ Coronary Bypass Graft
□ Dementia □ Alzheimer's
□ Diabetes (Type: _____)
□ Eye Surgery
□ Hemodialysis
□ Hemolytic Anemia
□ Hepatitis (Type: _____)
□ Hypertension
□ Hypoglycemia
□ Leukemia
□ Lymphomas
□ Memory Impaired
□ Myasthenia Gravis
□ Pacemaker
□ Renal Failure
□ Seizure Disorder
□ Sickle Cell Anemia
□ Glaucoma
□ Stroke (Year: _____ Impairments: _____)
□ Tuberculosis
□ Vision Impaired
□ Other: _____
□ Other: _____
□ Hearing Impaired
□ Prosthetic Heart Valve
□ Other: _____
□ Other: _____