

Vial of Life LAST UPDATED: \_\_\_\_\_\_\_\_\_\_\_\_

Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blind: Y / N ? Deaf Y/N  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_

Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_\_

Gender(circle one): Male / Female  
Marital Status(circle one): Single/ Married/ Widowed/ Divorced  
Primary Insurance Company Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Company Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Advance Directive for Health Care (circle one)? Yes/ No?  
Name of Agent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Do you have Do Not Resuscitate (DNR) Order? Y / N (If Yes, attach)  
Notify In Case of Emergency:

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Phone Number |
|  |  |  |
|  |  |  |
|  |  |  |

Others Living in the Home:

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Phone Number |
|  |  |  |
|  |  |  |

Pet Name /Type:\_\_\_\_\_\_\_\_\_\_\_ Pet Sitter Name:\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_



Medical Information

Physician Information:

|  |  |  |
| --- | --- | --- |
| Primary and Specialty Physician’s Names | Role | Phone |
|  |  |  |
|  |  |  |

Location of Medical Records: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Normal Blood Pressure:\_\_\_/\_\_\_ Height\_\_\_\_\_ Weight\_\_\_\_

Drug Allergies (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergies (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medical problems/physical disabilities do you have? (or example, heart problems, diabetes, high blood pressure, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgeries (type and date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Wear or Use (circle one):

|  |  |  |  |
| --- | --- | --- | --- |
| Dentures | Yes/No | Glasses | Yes/No |
| Contacts | Yes/No | Hearing Aids | Yes/No |
| Oxygen | Yes/No | Wheelchair | Yes/No |

Where do you keep your medications?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications (include prescription and over the counter drugs, vitamins & herbal supplements):

| Name of Medication | Dosage | Times |
| --- | --- | --- |
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Source: Sharpe Senior Resource Center