Vial of Life LAST UPDATED: ____________

Name : ______________________

Address: ____

Phone No.: ____________________

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		

Where do you keep your medications?______________________________________

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

Name of Medication	Dosage	Times

Source: Sharpe Senior Resource Center