VIAL of LIFE

A project of Area Agency on Aging 1-800-510-2020

Name ______________________ Today's Date __________

Address ______________________ Phone __________

City, State Zip ______________________

Date of Birth ______________________ Sex Male Female

Height ______________________ Weight __________

Social Security No ______________________ Medicare No __________

Secondary Insurance Co ______________________ Policy No __________

I have an Advanced Directive Yes No Location __________

(ex. Do Not Resuscitate, Living will, Durable Health Care Power of Attorney)

Notify in Emergency

Name ______________________ Relationship __________ Phone __________

Name ______________________ Relationship __________ Phone __________

MEDICAL INFORMATION

Primary Care Physician ______________________ Phone __________

Secondary Physician ______________________ Phone __________

Hospital Records at ______________________

Pharmacy ______________________ Normal Blood Pressure __________

Drug Allergies ______________________

____

Food Allergies ______________________

____

MEDICAL INFORMATION

What medical problems do you have?

Allergies	Cancer	Heart	Mental Health.
Alzheimer's/ Dementia	Cholesterol	High Blood Pressure	Stroke.
Arthritis	Diabetes	Other ______	
Asthma	Eye/Vision	______	

Past Surgeries (Type and date) ______

______

______

______

Blood Type ______

Do you	wear dentures	wear glasses	wear Hearing Aids .
	wear contacts	Use Oxygen	

CURRENT MEDICATIONS

(Include Over-the- Counter Medications)

Name	______	Dosage	______	Time	______
Name	______	Dosage	______	Time	______
Name	______	Dosage	______	Time	______
Name	______	Dosage	______	Time	______
Name	______	Dosage	______	Time	______
Name	______	Dosage	______	Time	______
Name	______	Dosage	______	Time	______
Name	______	Dosage	______	Time	______
Name	______	Dosage	______	Time	______

Where to you keep your medications? ______