Vial of Life
Medical Information Form

Name:______________________________ Address: ______________________________

Home Phone #: ______________________ Lives With: ____________________________

Birthdate: __________________ Social Security #:_______-_______-______ Sex: M / F

Eye Color: _________ Hair Color: _________ Height: __________ Weight: _________

Ambulatory: Y / N Medicare #: __________________ MediCal #: _________________

Other Insurance: ____

Hospital Preference: ___________________ Primary Language: __________________

Physician: ______________________________ Phone #: ___________________________

Emergency Contact: Name: ____________________ Relationship: _________________

Home Phone #: _____________________ Work Phone #: ____________________________

Do you have an Advanced Directive (*Durable Power of Attorney for Healthcare, Prehospital Do Not Resuscitate*)? Y / N. If you want these wishes followed, enclose a copy in this vial.

Medical History: ____

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Medications:____

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____

Allergies:____

Minister / Priest / Rabbi / Other (Circle one)

Name:______________________________ Phone #: ______________________________

Comments: ____