File of Life

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING

Please list prescriptions and over-the-counter medications (ex: aspirin, antacids) and herbals (ex: ginseng, ginkgo). Make sure to include the routinely and "as needed" medications.

Name of Medicine	Dose	How Often You Take

EMERGENCY MEDICAL INFORMATION

(Use your computer to complete this section)

Last Updated:			
Name:			
Male / Female / Other		Date of Birth:	
Social Security Number:			
Address:			
Your Telephone Number:			
Primary Doctor:			
Primary Doctor Telephone:			
Preferred Pharmacy:			
Pharmacy Telephone:			
Medical Insurance Company:			
Policy Number:			
Medical Insurance Company:			
Policy Number:			
Medicare / Medicare			
Policy Number:			

EMERGENCY CONTACTS

1st Name:	
1st Telephone Number:	
1st Address:	
2nd Name:	
2nd Telephone Number:	
2nd Address:	

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DNR: (Yes) / (No)
If yes, Location:

Health Care Power of Attorney
(Yes) / (No) If yes, who:

MEDICAL HISTROY INFORMATION

Recent Surgeries / Hospilizations:

For:	Where:	Where:

ALLERGIES: (check all that apply)

☐	Aspirin	☐	Lidocaine
☐	Barbiturates	☐	Morphine
☐	Codeine	☐	Novocain
☐	Demerol	☐	Penicillin
☐	Insect Stings	☐	Sulfa
☐	Horse Serum or Vaccines	☐	Tetracycline
		☐	X-Ray Dye
☐	Latex	☐	No Known Allergy

ADDITIONAL ALLERGIES & REACTIONS (describe)

ALLERGY	REACTION

Update this form whenever you have a change of medication or medical history.

Keep a copy in a easy to access location
(ex: on the fridge, wallet, purse)

MEDICAL CONDITIONS: (check all that apply)

	HEART DISEASE		**LUNG DISEASE**
☐	CHF/Heart Failure	☐	COPD/Emphysema
☐	High Blood Pressure	☐	Asthma
☐	Low Blood Pressure	☐	Fibrosis
☐	Irregular Heart Beat	☐	Pneumonia
☐	High Cholesterol	☐	Bronchitis
☐	Pacmaker	☐	Shortness of Breath
☐	Heart Attack	☐	Coughing
☐	Angina/Chest Pains	☐	Lung Pains
☐	Heart Surgery/Bypass	☐	
☐	Heart Stent	☐	
	KIDNEY DISEASE		**STOMACH DISEASE**
☐	Failure	☐	Bowel Obstruction
☐	Insufficiency	☐	Bleeding
	Dialysis:	☐	Diverticulitis
☐	via Belly	☐	Hiatal Herinia
☐	via center	☐	GERD/Reflux
☐	Kidney Stones	☐	Diarrhea
☐	Infections	☐	Blood in Stools
☐		☐	
	NEUROLOGICAL DISEASE		**MALIGNANCY/CANCER**
☐	Stroke	☐	Breast L / R
☐	Bleeding in Brain	☐	Colon
☐	Seizures	☐	Leukemia
☐	Multiple Sclerosis	☐	Liver
☐	Parkinson's	☐	Lung L / R
☐	Headaches	☐	Skin
☐	Alzheimers/ Memory Loss	☐	Stomach
☐		☐	
	ENDOCRINE DISEASE		**OTHER**
☐	Diabetes	☐	Arthritis
	Thyroid:	☐	Colon
☐	High	☐	Back Pain
☐	Low	☐	HIV
☐		☐	Sickle Cell
☐		☐	Weight Gain
☐		☐	Weight Loss
☐		☐	Vision Issues
☐		☐	

ADDITIONAL MEDICAL CONDITIONS
