File of Life

Additional Forms at: emsfiresoftware.com

Information current as of: ____ / _____ /200__

Name:

Address: Birthdate: / /

Sex: M F

Blood Type:

Phone: (_____) _____ - _____ Phone 2: (_____) _____ - _____

Communicable Disease(s):

Primary Doctor: Last appt: / /

See for:

Other Doctor: Last appt: / /

See for:

Other Doctor: Last appt: / /

See for:

Hospital of Choice:

Health Proxy: N Y filed at: Living Will: N Y filed at:

DNR: N Y located: date:___/___/____ by Dr. _____

(Circle) **Past Medical History**: Angina, Asthma, Cardiac, Cardiac Arrest, Dementia, Alzheimer's, Diabetes, Dialysis, Eye, Hearing, Hypertension, Leukemia, Pacemaker/AICD, Renal, Seizures, Stroke/TIA, *Other:*

Medication	Dosage	Frequency