# File of Life

Additional Forms at: emsfiresoftware.com

*Information current as of: ____ / _____ /200__*

Name:

Birthdate: ____ /_____/_____ | Sex: M F

Address: _____

_____

Phone: (_____) _____ - _____

Communicable Disease(s): _____

Primary Doctor: _____

See for: _____ Last appt:___/___/___

Other Doctor: _____

See for: _____ Last appt:___/___/___

Other Doctor: _____

See for: _____ Last appt:___/___/___

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 |
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