File of Life

Additional Forms at: **emsfiresoftware.com**

Information current as of: ____ / _____ /20___

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 location: _____

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