# Emergency Medical Information Form

VIAL OF LIFE — FILE OF LIFE

Date Completed: _____

## NAME:

| First | Middle Initial | Last | Date of Birth |
|---|---|---|---|
| | | | |

## MEDICAL CONDITIONS:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Stroke
- ☐ Asthma
- ☐ COPD
- ☐ Arthritis
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Alzheimer's Disease/ Dementia
- ☐ Other (please specify)

## ALLERGIES (Food, medication and/or environmental)

## SURGERIES AND DATES:

| Surgery: | Date: | Surgery: | Date: |
|---|---|---|---|
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## PHYSICIANS:

| Name: | Specialty: | Address: | Phone: |
|---|---|---|---|
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## HOSPITAL PREFERENCE:

## HEALTH INSURANCE COMPANY:

## PETS:

Please contact _____ (Name) at _____ (Phone #) to care for my pet, _____ (Pet's Name).

## EMERGENCY CONTACTS:

| Name: | Relationship: | Home Phone: | Work Phone: |
|---|---|---|---|
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## MEDICATIONS:

| Name: | Dosage/Strength: | Quantity: | Purpose/Special Instructions: |
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## ADVANCE DIRECTIVES/LIVING WILL:

Do you have an Advance Directive/Living Will? ○ YES ○ NO

- *Consider filing a scanned copy of your advance directive/living will on the File of Life flash drive.*

**Additional forms available at SunHealthWellness.org/VialofLife or by calling (623) 832-9355**