VIAL OF LIFE Emergency Medical Information Form

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

PHYSICIANS:

Name	Specialty	Address	Phone

HOSPITAL PREFERENCE:

_____

HEALTH INSURANCE COMPANY:

_____

PETS:

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

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VIAL OF LIFE

Emergency Medical Information Form

EMERGENCY CONTACTS:

Name	Relationship	Home Phone	Work Phone

MEDICATIONS:

Name	Dosage/Strength	Quantity	Purpose/Special Instructions

ADVANCE DIRECTIVES/LIVING WILL:

Do you have an Advance Directive/Living Will?

☐ Yes

☐ No

Additional forms available at **SunHealthWellness.org/VialofLife**
or by calling **(623) 471-9355**

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