COX Homelife Care℠ | VIAL OF LIFE

EMERGENCY MEDICAL INFORMATION

Please check and update this form monthly for accuracy!

Date Completed: _____

Updated: _____

BASIC INFORMATION

Name: _____

Street: _____ City: _____ State: _____

Zip: _____ Phone: _____

In Case of Emergency, Please Notify: _____

Phone: Relationship: _____

Street: _____ City: _____ State: _____

IDENTIFYING INFORMATION

Male ☐ Female ☐ Height: _____ Weight: _____

Date of Birth: _____ Marital Status: _____

Hair Color: _____ Eye Color: _____

Blood Type: _____ Religion: _____

Primary Language Spoken: _____ Other Language(s): _____

Glasses ☐ Hearing Aid ☐ Left ☐ Right ☐ Blind ☐ Left ☐ Right ☐

Contact Lenses ☐ Right Deaf ☐ Left ☐ Right ☐ Artificial Eye ☐ Left ☐ Right ☐

False Teeth/Bridge ☐ Left ☐ Right ☐

Artificial Limbs or Prosthetic Devices: _____

Pacemaker Model #: _____

Defibrillator Model #: _____

Identifying Marks (i.e., birthmarks, tattoos, etc.): _____

Normal Blood Pressure: _____ /_____ /_____ Smoker ☐ Non-Smoker ☐

MEDICAL HISTORY

Check Conditions that you have been treated for:

Allergies ☐ Blood Pressure ☐ Epilepsy ☐ Heart Condition ☐ Tuberculosis ☐ Anemia ☐

Cancer ☐ Glaucoma ☐ Jaundice ☐ Arthritis ☐ Diabetes ☐ Hay Fever ☐ Sinus ☐

Asthma ☐ Insulin ☐ Hepatitis ☐ Stroke ☐

CURRENT MEDICAL INFORMATION

Name of Doctor:_____ Phone #: _____

Name of Doctor:_____ Phone #: _____

Currently Being Treated For: _____

_____

_____

CURRENT MEDICATIONS

Medication	Dosage	Taken How Often? (Frequency)	Taken to treat what condition?	Located where in your home?

Allergies to Medications: _____

_____

HOSPITAL INFORMATION

Hospital Preference: _____ City _____

State _____ Last Hospitalization: _____

Hospital: _____ Date: _____

Treated For: _____

Living Will If yes, location of Living Will: _____

Do Not Resuscitate (DNR) Order Location of DNR: _____

Organ Donor _____

MEDICAL INSURANCE COVERAGE

Medicare #: _____ Medicaid #: _____

Insurance Policy #: _____