File of Life

Print information below in pencil. **Give special attention to the Allergies and Medications sections.**

Fold in half lengthwise, then fold in quarters. Then place in a red plastic magnetic File of Life holder on the **outside of your refrigerator**. These are available from the WB VFD.

Update this information whenever anything on it changes. **Review this at least twice a year.**

It can be helpful to make a copy of this to bring with you to doctor's appointments.

This form can be found online at http://www.whitebluffnow.com/emergencies.html or from the WB VFD.

Personal Data

Date filled out (remember to change this as you revise the form)					
Name		Sex		Date of Birth	
Address					
Phone		Religion			

Primary Physician		Phone	
Secondary Physician		Phone	
Hospital Preferred			

Allergies

Drug / Food	Reaction	Drug / Food	Reaction

Medications (Include both Prescriptions and Over-the-Counter Supplements)

Name	Dosage	Name	Dosage

Where do you keep your medications?			
Are you currently on Chemotherapy?	Yes / No		
Are you on a Blood Thinner?	Yes / No	How much / How often?	
Are you on Insulin?	Yes / No	How much / How often?	
Are you using Oxygen?	Yes / No	How many liters?	

Be sure to complete reverse side

In Case of Emergency, Notify:

Name		Daytime Phone		Evening Phone	
Address				Relationship	
Name		Daytime Phone		Evening Phone	
Address				Relationship	

Medical Insurance

Primary Insurance		Policy #		Phone	
Secondary Insurance		Policy #		Phone	
Medicare #		Medicaid #			

General Health Information

Blood Type				
Pacemaker?	Yes / No	Model #		
Glasses?	Yes / No	Contacts?	Yes / No	
Hearing Aid?	Yes / No	Dentures?	Yes / No	
Any other Prostheses?	Yes / No	Describe		
Do you presently have any medically inserted tubes in your body?	Yes / No	Describe		

Surgeries

Name	Date	Name	Date

Immunizations

Name	Date	Name	Date
Pneumonia PCV13		Tetanus	
Pneumonia PPSV23		Shingles	
Flu			

History

Have you been diagnosed or treated for

Heart Disease	Yes / No	Diabetes (high sugar)	Yes / No	Gastric Disease	Yes / No
Rheumatic Fever	Yes / No	Hypoglycemia (low sugar)	Yes / No	Ulcers	Yes / No
Congenital Heart	Yes / No	Anemia	Yes / No	Hiatal Hernia	Yes / No
Heart Murmur	Yes / No	HIV / AIDS	Yes / No	Liver Disease	Yes / No
Congestive Heart Failure	Yes / No	Tendency to Bleed	Yes / No	Hepatitis	Yes / No
Stroke	Yes / No	Respiratory Disease	Yes / No	Jaundice	Yes / No
Abnormal Blood Pressure	Yes / No	TB	Yes / No	Gall Bladder Disease	Yes / No
Edema / Swelling	Yes / No	Asthma	Yes / No	Arthritis	Yes / No
Glaucoma	Yes / No	COPD	Yes / No	Epilepsy	Yes / No
Cataracts	Yes / No	Emphysema	Yes / No	Cancer	Yes / No

If you have had Cancer, please list the type(s) of cancer ____