



**vial
of life**

providing EMTs with life-saving information
even when you may be unable to communicate

sponsored by the north fork ambulance association

Date Created: _____

MEDICAL INFORMATION FORM

Name: (First, Middle, Last) – Example: John Henry Smith		Date of Birth:	
Age:	Sex: Male Female	Doctor's Name:	
Do you have a Do Not Resuscitate Order (DNR)? Yes No		If yes, where is it located?	
Medical Conditions:			
<u>Cardiac (Heart) Conditions:</u>	<input type="checkbox"/> Aneurysm	<u>Other Medical Conditions:</u>	
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Epilepsy (Seizures)	
<input type="checkbox"/> High Blood Pressure	<u>Respiratory Conditions:</u>		<input type="checkbox"/> Medicine Patches
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> AIDS	
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Emphysema/Bronchitis	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Internal Defibrillator	<input type="checkbox"/> COPD	<input type="checkbox"/> Cancer - _____	
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Stomach Ulcer	
<input type="checkbox"/> Pulmonary Edema	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Gastrointestinal Bleed	
<input type="checkbox"/> Abdominal Aortic Aneurysm	<u>Other Medical Conditions:</u>		<input type="checkbox"/> Kidney Failure - Dialysis
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke	<input type="checkbox"/> Other: _____	
Date(s): _____	Date(s): _____		
Allergies:			
<u>Medication Allergies- List:</u>	<u>Food Allergies – List:</u>	<u>Plant & Insect Allergies – List:</u>	
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	
Date & Reason of Last Emergency Room Visit:			
Date:	Reason:	Hospital:	
_____	_____	_____	
_____	_____	_____	
Surgeries within the past 2 years:			
Date:	Procedure:	Hospital:	
_____	_____	_____	
_____	_____	_____	
Emergency Contact Information:			
Name:	Home Phone:	Cell Phone:	Relationship:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



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MEDICAL INFORMATION FORM – Continued

List of Current Medications & Medical Patches:		
Name of Medication	Why are you taking this?	How often do you take it?
1		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
2		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
3		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
4		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
5		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
6		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
7		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
8		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
9		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
10		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
11		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
12		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use

Alternative Medications/Herbal Remedies Which You Take Regularly:		
Name of Medication/Remedy	Why are you taking this?	How often do you take it?
1		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
2		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
3		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use
4		<input type="checkbox"/> Regular Use <input type="checkbox"/> As Needed <input type="checkbox"/> One-Time Use

- To Update Information:**
- General Information: Cross out old information and clearly write date of change next to new information.
 - Medication Changes: If you are no longer taking a medication, strike one line through the name of the medication. Add new medications as necessary.
 - Additional Medical Information forms may be obtained from one of the Vial of Life pick-up locations identified on the vial's label, or may be downloaded from our website at www.northforkambulance.com