

Vial of Life

Sponsored by **North Fork Ambulance**

Date Created: _____

First Name			Middle Name			Last Name				
Date of Birth			Age			Male/Female				
Doctor's Name			Do you have a DNR (Do Not Resuscitate) Order ?			Yes		No		
			If so, where is it ?							
Current Medical Conditions										
<input type="checkbox"/> Heart			<input type="checkbox"/> Cancer			<input type="checkbox"/> Low Blood Pressure			<input type="checkbox"/> Stroke	
<input type="checkbox"/> Asthma			<input type="checkbox"/> Bleeding Disorder			<input type="checkbox"/> Diabetes			<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Seizures			<input type="checkbox"/> High Blood Pressure			<input type="checkbox"/> AIDS			<input type="checkbox"/> Emphysema	
<input type="checkbox"/> Other (list)						<input type="checkbox"/> Epilepsy			<input type="checkbox"/> Internal Defibrillator	
									<input type="checkbox"/> Medicine Patches	
Past Medical Conditions (last 5 years)										
<input type="checkbox"/> Heart			<input type="checkbox"/> Cancer			<input type="checkbox"/> Low Blood Pressure			<input type="checkbox"/> Stroke	
<input type="checkbox"/> Asthma			<input type="checkbox"/> Bleeding Disorder			<input type="checkbox"/> Diabetes			<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Seizures			<input type="checkbox"/> High Blood Pressure			<input type="checkbox"/> AIDS			<input type="checkbox"/> Emphysema	
<input type="checkbox"/> Other (list)						<input type="checkbox"/> Epilepsy			<input type="checkbox"/> Internal Defibrillator	
									<input type="checkbox"/> Medicine Patches	
Allergies										
Date and Reason for Last Emergency Room Visit or Hospitalization										
Past Surgeries?										
Bleeding Problems?										
Emergency Contact Notification - Name - Address - Phone - Relationship										

To update this form, ADD THE DATE for each item you added or changed