Vial of Life

Personal Information Worksheet

FULL NAME *Te Llamas*

MAILING ADDRESS *Su direccion de correo* APT #

CITY *Ciudad, estado, codigo postal* **STATE** **ZIP CODE**

SSN *Seguro Social* **PHONE** *Telefono*

MEDICAL INSURANCE *Seguro Medico*

POLICY # *Politica* GROUP # *Grupo*

DOB *Feche de nacimiento* **GENDER** *Genero*

◯ M ◯ F

EMERGENCY CONTACT #1 *Contacto de emergencia*

Name *Nombre*:

Phone *Telefono*:

EMERGENCY CONTACT #2 *Contacto de emergencia*

Name *Nombre*:

Phone *Telefono*:

PRIMARY PHYSICIAN *Medico Primario*

Name *Nombre*:

Phone *Telefono*:

PHARMACY *Farmacia*

Phone *Telefono*:

ADVANCED DIRECTIVE? *Directiva Avanzada*

◯ Yes, Location:

◯ No

HOUSEHOLD MEMBERS *Miembros de la familia*	**AGES** *Edades*

MEDICAL HISTORY *Historia Clinica*

◯ ALZHEIMER'S ◯ CHF ◯ DIABETIC ◯ HIGH CHOLESTEROL ◯ RENAL FAILURE

◯ ASTHMA ◯ COPD ◯ DIALYSIS ◯ HIGH BLOOD PRESSURE ◯ RESP FAILURE

◯ CANCER ◯ CVA / STROKE ◯ EMPHYSEMA ◯ HIV / AIDS ◯ SEIZURE

◯ CARDIAC / HEART ◯ DEMENTIA ◯ HEPATITUS ______ ◯ INTUBATION ◯ SUBST. ABUSE

◯ OTHER *(Cancer Type, Stroke Deficits, etc.)*: ◯ PSYCH PROBLEMS ◯ TUBERCULOSIS

MEDICATIONS *Medicacion*	**REASON FOR TAKING** *Razon*	**DOSAGE** *Dosification*

ALLERGIES *Alergias*	**EXPECTED REACTION** *Reacción esperada*

PREFERRED HOSPITAL *Recomendado Hospital*

DATE COMPLETED *Fecha de Finalizacion*