
Sharpe Senior Resource Center

VIAL of LIFE (858)939-4790

Name : _____

Address _____

Phone No. _____

Gender (circle one) : Male / Female

Marital Status: Single / Married / Widowed / Divorced

Primary Insurance Company Policy Number _____

Secondary Insurance Company Policy Number _____

Have you filled out an Advance Directive for Health Care Form?

Name of Agent _____ Phone: _____

Have you requested a Do Not Resuscitate Order? Y / N (If Yes, attach)

Notify In Case of Emergency:

Name	Relationship	Phone Number

Others Living in the Home:

Name	Relationship	Phone Number

Pet Name /Type: _____ Pet Sitter Name: _____ Phone: _____

Medical Information

Physician Information:

Primar and Specialty Physician's Names	Phone
Primary	
Specialty	
Specialty	

Location of Medical Records: _____

Normal Blood Pressure: ___ / ___ Height _____ Weight _____

Drug Allergies (specify): _____

Food Allergies (specify): _____

What medical problems/physical disabilities do you have? (or example, heart problems, diabetes, high blood pressure, etc.)

Past Surgeries (type and date)

Do You Wear or Use (circle one):

Dentures	Y / N ?	Glasses	Y / N ?
Contacts	Y / N ?	Hearing Aids	Y / N ?
Oxygen	Y / N ?		

Where do you keep your medications? _____

