CITY OF EDINA LIFE FILE FORM

Please fill out in pencil so changes can be made as needed

Date when last changed/updated:______________________________ Sex: ___M / ___F

Name: ______________________________ Phone #: ______________

Addr: ______________________________ Cell #: ______________

City/St/Zip: ______________________________

Birth date: ______________ Soc. Sec. # (Opt.): ______________

Religion: ______________ Blood Type: ______________

Doctor: ______________________________ Phone #: ______________

Doctor: ______________________________ Phone #: ______________

Hospital Preference: ______________________________

MEDICAL INSURANCE

Medicare #: ______________ Medicaid #: ______________

Medical Ins. Co: ______________________________

Policy/ID #: ______________________________ Group: ______________

Medicare Part D Provider: ______________________________

EMERGENCY CONTACTS

Name: ______________________________ Phone #: ______________

Addr: ______________________________ Cell #: ______________

City/St/Zip: ______________________________

Relationship: ______________ Email: ______________________________

Name: ______________________________ Phone #: ______________

Addr: ______________________________ Cell #: ______________

City/St/Zip: ______________________________

Relationship: ______________ Email: ______________________________

ALLERGIES TO MEDICATIONS (Check all that exist)

___No Known Allergies ___Other: ______________________________

___Aspirin	___Codeine	___Insect bite/sting	___Penicillins
___Bacitracin	___Erythromycins	___Latex	___Streptomycin
___Barbiturate	___Demerol	___Lidocaine	___Sulfa
___Cephalosporins	___Eggs	___Morphine	___Tetracyclines
___Ciprofloxacin	___Horse Serum	___Novocain	___X-Ray Dyes

Environmental: ______________________________

Food: ______________________________

MEDICAL CONDITIONS (Check all that exist)

___No Known Medical Conditions

___Abnormal EKG
___Adrenal Insufficiency
___Alzheimer's
___Angina
___Angioplasty/Stents
___Asthma
___Bleeding Disorder
___Coronary Bypass Graft
___COPD/Emphysema
___Clotting disorder
___Dementia
___Diabetes
___Fractures
___Memory Impairment
___Hearing Impairment
___Heart Attack
___Hemodialysis
___High Blood Pressure
___HIV/AIDS
___Hypoglycemia
___Laryngectomy
___Leukemia
___Lymphoma
___MS
___Myasthenia Gravis
___Pacemaker
___Seizures
___Speech Impairment
___Stroke
___Thyroid Disorder
___Tuberculosis
___Vision Impairment
___Anxiety
___Depression
___Bipolar
___Schizophrenia

___Anemia – type: ____________________________
___Hepatitis – type: __________________________
___Arthritis – type: ____
___Cancer – type: ____
___Other: ____

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Recent Surgery: ____ Date: ________________________
Recent Surgery: ____ Date: ________________________
Recent Surgery: ____ Date: ________________________

CURRENT MEDICATIONS

Medication/Supplement	Dosage	Frequency	Medical Condition

Pharmacy: ____ Phone #: __________________________
Health Care Directive on file at: ____
DNR/DNI form? ___YES ___NO - Location : ____
Special Conditions: ____

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Comments/Additional Info: ____

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If more space needed – please attach additional sheets