# 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 | ☐ Clotting disorder | ☐ HIV/AIDS | ☐ Speech Impairment |
| ☐ Adrenal Insufficiency | ☐ Dementia | ☐ Hypoglycemia | ☐ Stroke |
| ☐ Alzheimer's | ☐ Diabetes | ☐ Laryngectomy | ☐ Thyroid Disorder |
| ☐ Angina | ☐ Fractures | ☐ Leukemia | ☐ Tuberculosis |
| ☐ Angioplasty/Stents | ☐ Memory Impairment | ☐ Lymphoma | ☐ Vision Impairment |
| ☐ Asthma | ☐ Hearing Impairment | ☐ MS | ☐ Anxiety |
| ☐ Bleeding Disorder | ☐ Heart Attack | ☐ Myasthenia Gravis | ☐ Depression |
| ☐ Coronary Bypass Graft | ☐ Hemodialysis | ☐ Pacemaker | ☐ Bipolar |
| ☐ COPD/Emphysema | ☐ High Blood Pressure | ☐ Seizures | ☐ Schizophrenia |

☐ Anemia – type: _____ ☐ Hepatitis – type: _____

☐ Arthritis – type: _____

☐ Cancer – type: _____

☐ Other: _____

_____

Recent Surgery: _____ Date: _____

Recent Surgery: _____ Date: _____

Recent Surgery: _____ Date: _____

## CURRENT MEDICATIONS

| Medication/Supplement | Dosage | Frequency | Medical Condition |
|---|---|---|---|
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Pharmacy: _____ Phone #: _____

Health Care Directive on file at: _____

DNR/DNI form? ☐ YES ☐ NO - Location : _____

Special Conditions: _____

_____

Comments/Additional Info: _____

_____

_____

_____

If more space needed – please attach additional sheets