VIAL OF LIFE

PLEASE COMPLETE IN PENCIL, Update as information or prescriptions change
Go to www.sac-panhandle.com to use a computer fillable form or print a blank one

Today's Date: _____

Update: _____

Name: _____

Address: _____

City: _____

State, Zip Code: _____

Date of Birth: _____

Primary Doctor: _____

Doctor's Phone #: _____

Specialty Physician: _____

Specialty Phone#: _____

My pets that need attention:

_____

Living Will-DNR Order:

☐ **Yes** ☐ **No**

(Attach Copies to this document)

Medical Power of Attorney

☐ **Yes** ☐ **No**

Who: _____

Phone: _____

In Case of Emergency Notify:

Name: _____

Address: _____

Phone #: _____

Relationship: _____

OR

Name: _____

Phone #: _____

Relationship: _____

Insurance Co: _____

Phone #: _____

Check any of the following conditions if you HAVE or HAVE HAD in the past:

☐ **Heart Problems** ☐ **Diabetes**

☐ **Stroke** ☐ **Seizures**

☐ **Lung-Breathing** ☐ **Bleeding**

☐ **High Blood Pressure** ☐ **Alzheimer's**
☐ **Memory Problems**

☐ **Speech-Hearing Difficulty**

Other: _____

Medical History (within last year):

_____

_____

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Surgeries:

_____

_____

_____

Allergies (medications or other):

_____

_____

_____

Check all that apply:

☐ **Dentures**
☐ **Glasses-Contacts**

☐ **Hearing Aid**
☐ **Pacemaker**

☐ **Oxygen**
☐ **Mobility Device**

Immunization Record:

☐ TDaP
☐ Seasonal Flu
☐ Shingles

☐ Pneumonia

Other recent Immunizations (within the last 5 years) _____

CURRENT MEDICATIONS:

*(Include non-prescription medications **Such as Vitamins or any Homeopathic)*

Medications	Dosage	Frequency