



THE HEALTH PLAN OF THE UPPER OHIO VALLEY

ENVELOPE OF LIFE



*Completion of this form will provide valuable information to medical personnel such as an EMT, Paramedic, or an Emergency Room Doctor in the event of an emergency.

Name: Date of Birth:

Address: City: State: ZIP:

Phone: Blood Type: Male Female

Primary Language Spoken: Religion/Church Affiliation:

Do you wear? (check all that apply): Glasses Contact Lenses Dentures/Partials Hearing Aid(s)

Are you ? (check all that apply): Blind Deaf Hard of Hearing Pregnant

Normal Mental Status (check one): Alert/Oriented Alert/Some Impairment Confused/Disoriented

Do you have Advance Directives?: Yes No Living Will (location):

Medical Power of Attorney Name: Phone:

EMERGENCY CONTACTS

Name: Phone: Relationship:

Name: Phone: Relationship:

ALLERGIES

Medication Allergies?: No Yes List:

Food/Latex/Other All:ergies?: No Yes List:

MEDICAL CONDITIONS *(check all that apply)*

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Lung Disease/Asthma | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Stroke(s) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Paralysis/Weakness | <input type="checkbox"/> Bladder Disorder |
| <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Gastrointestinal Disorder | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Other List: <input style="width: 650px;" type="text"/> | | | |

MEDICAL DEVICES *(check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Pacemaker Brand: <input style="width: 150px;" type="text"/> | <input type="checkbox"/> Stents |
| <input type="checkbox"/> Defibrillator Brand: <input style="width: 150px;" type="text"/> | <input type="checkbox"/> Greenfield Filter |
| <input type="checkbox"/> Prosthetics (including hip & knee replacements) Location: <input style="width: 100px;" type="text"/> | <input type="checkbox"/> Cerebral Shunt |
| <input type="checkbox"/> Hemodialysis Catheter Shunt Location: <input style="width: 200px;" type="text"/> | <input type="checkbox"/> Oxygen Therapy |
| <input type="checkbox"/> Peritoneal Dialysis Catheter Location: <input style="width: 200px;" type="text"/> | <input type="checkbox"/> Other (list below): |

PROVIDERS

Preferred Hospital: Phone:

Primary Care Physician: Phone:

Specialist: Phone:

Specialist: Phone:

INSURANCE

Medicare #: Medicaid #:

Primary Insurance: Group: Policy #:

MEDICATIONS

Medication Name	Strength	Dosage	Time		
			<i>(check all that apply)</i>		
			<input type="checkbox"/> AM	<input type="checkbox"/> Noon	<input type="checkbox"/> PM
			<input type="checkbox"/> AM	<input type="checkbox"/> Noon	<input type="checkbox"/> PM
			<input type="checkbox"/> AM	<input type="checkbox"/> Noon	<input type="checkbox"/> PM
			<input type="checkbox"/> AM	<input type="checkbox"/> Noon	<input type="checkbox"/> PM
			<input type="checkbox"/> AM	<input type="checkbox"/> Noon	<input type="checkbox"/> PM
			<input type="checkbox"/> AM	<input type="checkbox"/> Noon	<input type="checkbox"/> PM
			<input type="checkbox"/> AM	<input type="checkbox"/> Noon	<input type="checkbox"/> PM
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			<input type="checkbox"/> AM	<input type="checkbox"/> Noon	<input type="checkbox"/> PM
			<input type="checkbox"/> AM	<input type="checkbox"/> Noon	<input type="checkbox"/> PM
			<input type="checkbox"/> AM	<input type="checkbox"/> Noon	<input type="checkbox"/> PM
			<input type="checkbox"/> AM	<input type="checkbox"/> Noon	<input type="checkbox"/> PM

Medications continued on a separate page?: Yes No

Where in your residence do you keep your medications?

OTHER INFORMATION

List any other information, including recent surgeries and/or infections in the last 12 months, which may be useful to emergency responders:

Signature _____

Date of Birth _____