Law Enforcement Community Seniors
Monroe CTriad For Senior Safety

FILE OF LIFE

MEDICAL DATA as of: ____________

BLOOD TYPE: ____________

NAME: ______________________ SEX: ☐ M ☐ F DOB: ____________

ADDRESS: ______________________ PHONE: ____________

PRIMARY DOCTOR: ______________________ PHONE: ____________

DOCTOR: ______________________ PHONE: ____________

HOSPITAL OF CHOICE: ☐ BRIDGEPORT ☐ ST. VINCENT'S ☐ GRIFFIN

EMERGENCY CONTACTS

NAME: ____________ RELATIONSHIP: ____________ PHONE: ____________

NAME: ____________ RELATIONSHIP: ____________ PHONE: ____________

MEDICAL ISSUES	MEDICATION	DOSAGE	FREQUENCY

SURGERIES: **DATE:**

______________________ ____________

______________________ ____________

______________________ ____________

______________________ ____________

______________________ ____________

MEDICAL CONDITIONS: (Check all that apply)

☐ No known medical condition	☐ Heart Attack
☐ AIDS / HIV	☐ Hepatitis
☐ Alzheimer's	☐ High Cholesterol
☐ Angina	☐ Liver Disease
☐ Asthma	☐ Mental Health Diagnosis
☐ Atrial Fibrillation	☐ Myasthenia Gravis
☐ Blood Pressure: ☐ High ☐ Low	☐ Pacemaker / Defibulator
☐ Cancer	☐ Post Traumatic Stress Disorder
☐ Cataracts	☐ Pulmonary Embolism
☐ Chronic Obstructive Pulmonary Disease	☐ Renal Failure
☐ Congestive Heart Failure	☐ Seizure Disorder
☐ Cognitive Impairment	☐ Stroke - CVA (Cardiovascular Accident) - TIA
☐ Diabetes: ☐ Type 1 - Insulin ☐ Type 2 - Non-Insulin	☐ Thyroid Disorder
☐ Dialysis	☐ Vision Impaired
☐ Gastrointestinal Issues	☐ Other:
☐ Glaucoma	☐ Other:
☐ Hearing Impaired	☐ Other:

ALLERGIES: (Check all that apply)

☐ No Known Allergies	☐ Insect Stings	☐ Penicillin
☐ Seasonal Allergies	☐ Latex	☐ Sulfa
☐ Amoxicillin	☐ Lidocaine	☐ Tetracycline
☐ Aspirin	☐ Morphine	☐ X-Ray Dye
☐ Barbiturates	☐ Novocaine	☐ Other:
☐ Codeine	☐ Nuts	☐ Other:

SPECIAL CONDITIONS / REMARKS: ____

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INSURANCE INFORMATION

Medicare Number: ______________________ Social Security Number: ______________________

Medicare Supplement Company: ______________________ Policy Number: ______________

Medicaid or Medicare Savings Plan Number: ______________________

Other Insurance: ______________________ Policy Number: ______________