



**City of Seabrook
Emergency Medical Service
Vial of Life Program**

Medical Information Form

PATIENT INFORMATION:

Name:	Date of Birth:	
Address:	Gender (circle one) Male Female	
City:	State:	Zip Code:
Phone:	Social Security #	

Primary Medical Diagnosis:		
Physician's Name:	Physician's Phone:	
Hospital Preference:	Have you been a patient there? (circle one) Yes No	
Medicare #	Other Health Insurance:	Policy #
Address:	Group #	

HEALTH INFORMATION:

	Medical History: (Circle All That Apply)
	<input type="checkbox"/> Heart Attack <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Psychiatric
	<input type="checkbox"/> Asthma <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Fainting
	<input type="checkbox"/> Seizures <input type="checkbox"/> Pacemaker/ Defib <input type="checkbox"/> Severe Allergies
	<input type="checkbox"/> Stroke <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hemophilia
	<input type="checkbox"/> Diabetic <input type="checkbox"/> Emphysema <input type="checkbox"/>
	<input type="checkbox"/> Cancer <input type="checkbox"/> COPD <input type="checkbox"/>
	<input type="checkbox"/> Hepatitis <input type="checkbox"/> CHF <input type="checkbox"/>
	<input type="checkbox"/> Anemia <input type="checkbox"/> AIDS <input type="checkbox"/>

Allergies to Medication:
Do you have an Advanced Directive, DNR or Out of Hospital (OOH) DNR? (circle one) Yes No
Where is it?

EMERGENCY CONTACTS:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone: