



**City of La Porte  
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:**

Current Medications / Dosage / Allergies / Etc.          (attach separate list if needed)	<b>Medical History:</b> <input type="checkbox"/> Heart <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Psychiatric <input type="checkbox"/> Stroke <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Fainting <input type="checkbox"/> Asthma <input type="checkbox"/> Severe Allergy <input type="checkbox"/> Seizures <input type="checkbox"/> Pacemaker / Defib <input type="checkbox"/> Hemophilia <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Cancer <input type="checkbox"/> Emphysema <input type="checkbox"/> Hepatitis <input type="checkbox"/> AIDS <input type="checkbox"/> Anemia
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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:

I certify that the information on this form is accurate and up-to-date. I also understand that emergency personnel may rely on this information and I agree not to hold emergency personnel responsible for inaccurate or out of date information.

**SIGNATURE (REQUIRED)** \_\_\_\_\_ **DATE COMPLETED** \_\_\_\_\_

PLEASE ATTACH A RECENT PHOTOGRAPH AND LIST OF ANY OTHER INFORMATION TO THIS FORM

Additional forms may be obtained at the City of La Porte EMS Headquarters at 10428 Spencer, La Porte, Texas 77571 or printed online at [www.lpems.org](http://www.lpems.org)