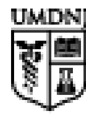

The UNIVERSITY HOSPITAL
University of Medicine & Dentistry of New Jersey

File Of Life Program

Name:	Age:	Date of Birth:

Address:	Phone:
Date of file or update:	Social Security Number:

General Health Information

Please indicate any medical conditions near the appropriate spaces. Include dates of any recent medical events ie. heart attack, stroke, etc.

Heart Condition/Pacemaker:
High Blood Pressure:
Diabetes:
Epilepsy:
Cancer:
Stroke:
Other Medical Conditions:
List any operations within the last 5 years:

List of Current Medications

Name	Dosage	Name	Dosage
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Allergies (Food, Medications, etc.):	
Special Information (Blood Type, Religion, DNR/Living Will):	
Primary Physician:	Phone:

Emergency Contact Information

Name:	Relationship:
Address:	Phone (home):
Phone (work):	Phone (cellular):