Medical Information (ICE) (File of Life)

Do you have a Colorado Advanced Directive of a DNR form? No ☐ Yes ☐ If yes, please attach.

KEEP INFORMATION UP TO DATE. Use pencil for ease in making changes.
Date this form has been updated:________________

Name:______________________________________ Date of Birth:________________
Sex: M F Hospital Preference:____
Doctor:_____________________________________ Phone #:________________
Doctor:_____________________________________ Phone #:________________
Emergency Contact:______________________________ Phone #:________________
Emergency Contact:______________________________ Phone #:________________

RECENT SURGERIES

____ Date:____________
____ Date:____________
____ Date:____________

ALLERGIES

☐ Aspirin
☐ Barbiturate
☐ Codeine
☐ Demerol
☐ Horse Serum
☐ Insect Stings
☐ Latex
☐ Lidocaine
☐ Morphine
☐ Novacaine
☐ Penicillin
☐ No Known Allergies
☐ Sulfa
☐ Tetracycline
☐ Contrast Dyes
☐ Environmental: ____
☐ Other: ____

MEDICAL CONDITIONS Check all that exist

☐ No known medical conditions
☐ Abnormal EKG
☐ Adrenal Insufficiency
☐ Angina
☐ Asthma
☐ Bleeding Disorder
☐ Prescription Blood Thinner
☐ Cancer
☐ Cardiac Dysrhythmia
☐ Cataracts
☐ Clotting Disorder
☐ Coronary Bypass Graft
☐ Dementia/Alzheimer's
☐ Diabetes/Insulin Dependent
☐ Eye Surgery
☐ Glaucoma
☐ Hearing Impaired
☐ Heart Valve Prosthesis
☐ Hemodialysis
☐ Hemolytic Anemia
☐ Hepatitis - Type [ ]
☐ Hypertension
☐ Hypoglycemia
☐ Other: ______________________________________
☐ Leukemia
☐ Lymphomas
☐ Memory Impaired
☐ Myasthenia Gravis
☐ Pacemaker/Defibrillator
☐ Renal Failure
☐ Seizure Disorder
☐ Sickle Cell Anemia
☐ Stroke
☐ Tuberculosis
☐ Vision Impaired

SPECIAL CONSIDERATIONS OR REMARKS

Please use this space for any information you feel may be useful in your care that has not been previously specified.

MEDICATIONS

Please enter all current medications (and the condition for which they are prescribed.) Include over-the-counter drugs and/or herbs that you take.

Medication	Medical Problem	Dosage	Frequency