File of Life

CITY OF CLEVELAND
Mayor Justin M. Bibb

Date Completed:	
What language(s) do you speak?	
Name:	
Address:	
City:	Zip Code:
Phone:	Gender:
Date of Birth:	Blind ☐ Deaf ☐
Social Security Number Last Four Digits:	
Marital Status:	
Medicare Number	
Other Insurance:	
Policy Number:	
Do you have an Advance Health Care Directive? Yes No	
If yes, where is the document located?	
If applicable, name and phone number of person with document:	
Do you have a Do Not Resuscitate order? Yes No	
Emergency Contacts; recommendation that one contact has a house key to secure home	
1.Name:	
Telephone #	Relationship:
2. Name:	
Telephone #	Relationship:
Religious preference:	
Pet's Information (Name & Type)	
Who should be called for pet care:	Telephone #
Medical Information	
Primary Doctor:	Telephone #
Secondary Doctor:	Telephone #
Medical Alert Device **This information is needed if the system needs to be reset**	
Do you have a medical alert device? Yes No	
If Yes, what is the company name and phone number?	

Medical Information			
Preferred Hospital:			Telephone #
Height : Weight:			Blood Type
Normal Blood Pressure:			
Allergies to drugs or foods:			
Please list any medical conditions that apply (for example: cardiac, diabetes, memory issues, stroke)			
Surgeries (type and date)			
Do You:			
Wear dentures? Yes No			Use Wheelchair? Yes No
Wear contacts? Yes No			Use Oxygen? Yes No
Wear hearing aids? Yes No			Wear glasses? Yes No
Medications (Prescription, Over-the-counter Drugs, Vitamins, Herbal Supplements)			
Name Dose-			Purpose
Name Dose-			Purpose
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If you need assistance completing this File of Life or want additional copies, please call the Cleveland Department of Aging at 216-664-2833.

Cleveland EMS recommends that you keep a copy of your advance directive in this File of Life.

It may also be helpful to include a current picture.

Find us online at Cleveland Department of Aging at www.clevelandohio.gov

Email at Aging@clevelandohio.gov