

Your husband or wife

Your spouse's name: _____

Note any health problems, dates diagnosed and course of treatment taken:

I *do* *do not* have a living will or other advance medical directives.
(For more details about living wills and other advance medical directives, see page 81.)

Name of hospital: _____

Name of primary care physician: _____

Address: _____

Phone number: _____

Name and address of other health care providers you see: _____

List of ongoing prescription medications being taken as of (date): _____
