

VIP Personal Information

Incident

Page 1 of 8

Incident Date

RM #

Last / Suffix / First / Middle Sex If Female/Maiden Name Age

DOB MM/DD/YYYY Race Ethnic Origin Ethnic Origin Other SSN # / ID #

Address Apt # City State Zip County Country

Birth City State or Country Birth Hospital Inside City Limits Religious Preference

Education: level completed: Elem/Second (0-12): College Degree Earned:

Alias 1 Last First Middle Alias 2 Last First Middle

Phone (H) (W) (Cell) Cell Type: Carrier:

Status Is Married Never Married Widowed Divorced Separated Civil Union Unk Wedding Date

Spouse Last Suffix Maiden/birth Name First Middle Living Deceased Unknown

Father Last Suffix First Middle Living Deceased Unknown

Mother Last Maiden/Birth Name First Middle Living Deceased Unknown

Informant Last Suffix First Middle Address City State Zip Home Phone Work Phone Cell Phone Country

- Relationship: Spouse, Daughter, Life Partner, Father, Uncle, Other, Mother, Aunt, Brother, Cousin, Sister, Employer, Son, Friend

Other:

E-mail Type of Initial Contact Initial Contact Date

Legal Next of Kin OK to Contact Legal Next of Kin? Yes No Make A Case Note To Explain

Last Suffix First Middle Address City State Zip Home Work Cell Phone Country E-mail

- Relationship: Spouse, Daughter, Life Partner, Father, Uncle, Other, Mother, Aunt, Brother, Cousin, Sister, Employer, Son, Friend

Other:

Contacts 1 Permanent Contact: YES Additional Contact? YES Last Suffix First Middle Address City State Zip Home Phone Work Phone Cell Phone

- Relationship: Spouse, Daughter, Life Partner, Father, Uncle, Other, Mother, Aunt, Brother, Cousin, Sister, Employer, Son, Friend

Other:

E-mail Type of Initial Contact Initial Contact Date

VIP Physical Description

Incident _____

Incident Date _____

RM # _____

Last	/	Suffix	/	First	/	Middle	Age	DOB	Sex	Race
------	---	--------	---	-------	---	--------	-----	-----	-----	------

Complexion: _____ General Build: _____

Height Inches: _____ / Height cm _____ Approx. Weight (Pounds): _____ / Weight Kilos _____

Hair Information

Hair Color Auburn Blonde Gray Salt and Pepper Dyed Black Brown Red White Other _____ Describe Other: _____

Hair Length Bald Short < 3" Male Pattern Baldness: _____ Describe Male Pattern Baldness: _____
 Shaved Medium Long

Hair Accessory Extensions Hair Piece Hair Transplant Wig N/A

Hair Description Curly Wavy Straight N/A Other: _____

Facial Hair Type Clean Shaven Beard & Mustache Goatee Sideburns N/A
 Mustache Beard Stubble Lower Lip

Facial Hair Color Auburn Blonde Gray Salt and Pepper Dyed Black Brown Red White Other _____ Facial Hair Notes: _____

Eye Color Blue Brown Green Hazel Gray Black Other: _____

Eye Status Both Intact Missing R Missing L Glass R Glass L Cataract

Optical Lens Contacts Glasses Implants None Desc. _____

Optical Color/Description of Glasses / Contacts: _____

Fingernail Type Natural Artificial Unknown Length Extremely Long Long Medium Short

Fingernail Color _____ Description _____

Toenail Type Natural Artificial Unknown

Toenail Color _____ Toenail description _____

Body Piercing(s)? Yes No Unk **Photos?** Yes No Unk **Photo Location** _____

#	Location	Side	Quantity	Description (include evidence of old piercings)	Photo
1					
2					
3					
4					
5					

Tattoo(s) Yes No Unk **Photos?** Yes No Unk **Photo Location** _____

#	Location	Side	Tattoo Description
1			
2			
3			
4			
5			

VIP Medical History

Page 3 of 8

Incident _____

Incident Date _____

RM # _____

Last

Suffix

First

Middle

Age

DOB

Sex

Race

Dentist

Dentist _____

Name of Practice: _____

Address _____

City _____

State _____

Zip _____

E-mail Address: _____

Phone W _____

Alt: _____

Fax _____

2nd Dentist: _____

Dental Insurance Company: _____

Braces Bridge Caps/Crowns Fillings Dentures Edentulous Tooth Jewelry Unknown

Doctor

Physician _____

Practice Name _____

Address _____

Physician Type _____

City _____

State _____

Zip _____

Reason Seen: _____

Phone W _____

Phone H _____

Date Last Seen: _____

Phone C _____

Fax _____

Email _____

Doctor

Physician _____

Practice Name _____

Address _____

Physician Type _____

City _____

State _____

Zip _____

Reason Seen: _____

Phone W _____

Phone H _____

Date Last Seen: _____

Phone C _____

Fax _____

Email _____

Medical Facility Visited / Type? _____

Medical Facility / Name _____

Medical History? Cancer High Blood Pressure Lung Disease Pregnancy Stroke Other

Medical History Notes / Other? _____

Medical Radiographs? Yes No Unk

Medical Radiographs Location: _____

Potential Type of Radiographs - and dates taken if known: _____

Old Fractures: Yes No Unk

Description: _____

Foreign Objects: Yes No Unk

Pacemaker Bullets Implants Needles Shrapnel Other

Describe Other: _____

Surgery: Yes No Unk

Gall Bladder

Laparotomy

Reconstructive

No

Appendectomy

Caesarean

Open heart

Unk

Tracheotomy

Mastectomy

Other

Unique Characteristics Yes No Unk

Description of: Scars or unusual body features: _____

Prosthetic(s) Yes No Unk

Prosthetic Location/Description _____

Circumcised? Yes No Unk

Tobacco User? Yes No Unk

Tobacco Type? _____

Diabetic? Yes No Unk

If Female, was she currently pregnant? Yes No Unk

If Female, was she pregnant during the last 12 months? Yes No Unk