PERSONAL HEALTH PROFILE

Patient Name:

Allergies:			
Advanced Directives:			
Emergency Contact:	**Name:**	**Telephone:**	**Cell Phone:**
Hospital Preferences:	**1st Choice:**	**2nd Choice:**	**3rd Choice:**
Insurance Information:	**Primary:**	**Contact #:**	**Benefits:**
Insurance Information:	**Secondary:**	**Contact #:**	**Benefits:**
Medical Diagnoses:			
Medications:	**Dosage:**	**Prescribing Physician:**	**Sensitivities:**
Immunization Status:	**Tetanus/date:**	**Other: _____**	**Other: _____**
Healthcare Providers involved in Care:	**Name/Phone #:**	**Name/Phone #:**	**Name/Phone #:**
Equipment:	**Vendor/contact #:**	**Description:**	**Date of last service:**
Equipment:	**Vendor/contact #:**	**Description:**	**Date of last service:**
Prosthesis/Orthosis:	**Provider:**	**Components/history:**	**Date of last service:**
Other:	**Provider/contact #:**	**Description:**	**Date of last service:**
Vision Issues:			
Hearing Issues:			
Swallowing Issues:			
Functional Status /Help Needed:			
Other Risk Factors:			