Portable Health Profile (PHP) Data Collection Form

This form contains information that is confidential. It may contain information that is privileged or exempt from disclosure under applicable law.

1. Personal Information

Name			Date
Street	City	State	Zip
Home Phone	Mobile Phone		
Date of Birth (mm/dd/yyyy)	Blood type		

2. Emergency Contacts

Name
Relationship
Street
City
State/Zip
Home Phone
Mobile Phone

Name
Relationship
Street
City
State/Zip
Home Phone
Mobile Phone

3. Medications

Medication Name	Dosage	Frequency	Provider	Phone Number

4. Known Allergies

5. Known Medical Conditions

Risk Factors: _____ Bleeding Precautions __Legally blind __Swelling problems __ hip precautions __sternal precautions __prone to fall __swallowing problems

6. Special Needs

Functional Mobility	
Vision/hearing	
Communication	
Other	

7. Immunizations

Name	Date Administered
Flu vaccine	
Pneumonia vaccine	
Tetanus	
Chicken pox vaccine	
HPV	

8. Healthcare Providers

Primary Physician	Phone Number
Dentist	Phone Number
Specialist 1	Phone Number
Specialist 2	Phone Number
Specialist 3	Phone Number

☐ Senior Network Health ☐ VNA ☐ home health care _____ oxygen provider _____

☐ Meals on wheels

9. Preferred Hospitals

Name	Phone Number

10. Health Insurance Information:

Primary Insurance Plan Name

Insured Name	Phone Number
ID Number	
Group Name	Group Number
Subscriber Name	
Subscriber Number/ID Number	

Secondary Insurance Plan Name

Insured Name	Phone Number
ID Number	
Group Name	Group Number
Subscriber Name	
Subscriber Number/ID Number	

11. Advance Directive: _____☐_HCP _____☐_DNR

12. Name of Healthcare Agent_____Phone Number_____

Location of your advanced directive? _____

Date updated: _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

13. Medical Devices (prosthesis, CPAP, Bipap, pacemaker, wheelchair, insulin pumps, hearing aids, durable medical equipment)

Device	Provider	Providers contact numbers	Date obtained or Date of last service