KERNAN ORTHOPAEDICS AND REHABILITATION
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

Date:

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 of Birth:	Sex:
Street:	City:	State:	Advance Directive □Yes □No
Home Phone:	Mobile Phone:		Primary Language:

2. Emergency Contacts

Name #1:
Relationship:
Address:
Phone #1:
Phone #2:

Name #2:
Relationship:
Address:
Phone #1:
Phone #2:

3. 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:	

Workers' Compensation Agency Name	
Claim Manager:	Phone Number:
Claim Number:	

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4. Immunizations

Name	Date Administered	Name	Date Administered
Flu Vaccine		Chicken Pox Vaccine	
Pneumonia Vaccine		HPV	
Tetanus			

5. Risk Factors

□ Legally Blind
□ Hip Precautions
□Swelling Problems
□ Sternal Precautions
□ Prone to fall
□ Bleeding Precaution

6. Physicians & Other Healthcare Providers involved in my care:

□Senior Network Health □VNA □Meals on Wheels
□Oxygen Provider: _____ □ _____Home Health Care

Primary Physician:	Phone Number:
Dentist:	Phone Number:
Specialist :	Phone Number:
Healthcare Provider:	Phone Number:
Healthcare Provider:	Phone Number:

7. Preferred Hospital

Name: _____ Phone Number:_____

8. Allergies: Please list any drug, food, substances to which you have had an allergic or bad reaction.

9. Medications/ Vitamins/Supplements :

Name	Dosage	Frequency (ex. Twice a day)

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

Device	Provider	Provider Number	Date obtained or last service

11. Known Medical Conditions/Diagnoses

□Anemia □Arthritis □Asthma □Bleeding Tendency □Cancer □Depression
□Diabetes □Heart Disease □Hepatitis □High Blood Pressure □High Cholesterol
□Kidney Disease □Liver Disease □Lung disease □SCI □Stroke/TIA □TBI □Ulcers
Others:

12. Special Needs

Functional Mobility:	
Vision/Hearing:	
Swallowing:	

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