Texas Rehabilitation Hospital of Fort Worth

Portable Patient Health Profile

Patient Information

Name:_____ Age:_____ Sex:_____ Height:_____

Weight:_____ Blood Type:_____ Race/Ethnicity: _____

Primary Family Contact:_____Home:_____Cell:_____

Emergency Contact:_____Home:_____Cell:_____

Do you have an Advanced Directive? (have a copy available if admitted to hospital):_____

Primary Care Physician Name:_____Phone:_____

Hospital Preference:_____Phone:_____

Insurance

Primary Medical: Company_____ Plan ID:_____

Group Number:_____ Policy Number:_____ Phone:_____

Conditions

Type of Condition:_____

Start Date:_____ End Date:_____

Treated by Physician:_____

Type of Condition:_____

Start Date:_____ End Date:_____

Treated by Physician:_____

Type of Condition:_____

Start Date:_____ End Date:_____

Treated by Physician:_____

Allergies

Medication/Food/Latex:_____

Describe Reaction:_____

Vision / Hearing

Do you wear glasses or contacts?_____ Blind:_____

Do you wear hearing aids? Right ear_____ Left Ear_____ Deaf:_____

Equipment / Devices

Describe any equipment or devices used:_____

Describe any orthotics, prosthetics used: _____

Vendor Phone Number:_____ Last date serviced:_____

Functional Status

Are you able to feed yourself?_____ Special Equipment:_____

Do you have problems swallowing?_____ Do you require thickened liquids?_____

Do you ambulate?_____ How far?_____

Can you dress your upper body? _____

Can you dress your lower body?_____Shoes?_____

Comments:_____

Risk Factors

Do you smoke? Y/ N How much per day?_____

Do you drink alcohol? Y/N How much per day?_____

Other Risk Factors:_____

Procedures

Type:_____ Date:_____Location:_____

Type:_____ Date:_____Location:_____

Type:_____ Date:_____Location:_____

Type:_____ Date:_____Location:_____

Test Results

Type of Test:_____Date:_____Result:_____

Type of Test:_____Date:_____Result:_____

Type of Test:_____Date:_____Result:_____

Type of Test:_____Date:_____Result:_____

Immunizations

Flu Shot Date:_____ PPD Date:_____

Pneumonia Shot Date:_____ Tetanus:_____

Comments:

Medication Name	Dosage	Frequency	Reason for taking medication