Portable Medical Profile (Adult)

Name: ______________________________ **Date of Birth:**________________ **Emergency Contact:** ______________________________
Name/Phone

Do you have a living will? Y/N Where is this information located? ______________________ Who has a copy? ___________________

Advance Directives: Who will make medical decisions for you if you are unable to make decisions about your care? ________________________

Allergies and Medication Sensitivities

Allergic To: Type of Reaction:

1.
2.
3.

Medical Diagnoses (Medical Conditions, Surgeries, Risk Factors, etc.)

1. 7.
2. 8.
3. 9.
4. 10.
5. 11.
6. 12.

Information for Medical Care Providers

Primary Care Physician:

Name:________________________________

Phone Number (office)________________

Other Physicians:

____

____

Dentist : ____________________________

Insurance Information

Insurance Carrier:____________________

Policy Number:______________________

Phone Number:_______________________

Case Manager:_______________________

Phone Number:_______________________

Secondary Insurance Information

Insurance Carrier:____________________

Policy Number:______________________

Phone Number:______________________

Prescription Coverage:_________________

Hospital Preference (in case of emergency)

Hospital:___________________________

Functional Status

Activity:	Safe: Y/N	Level of assist &/or equipment needed
Basic self care		
Feeding/Swallowing		
Walking ↑↓ stairs		
Walking in your home		
Community access (church, store etc.)		
Vision & Hearing		

Equipment and Devices used

Equipment description Vendor & contact # Date of last service

____

____

____

____

____

Orthotics or Prosthetics Information

Component Description Provider Date of last service

____

____

This medical profile was developed for Mary Free Bed patients as a tool to organize information about health care. Updating information whenever changes occur is important to maintain accuracy. For additional copies, please contact Mary Free Bed or visit www.maryfreebed.com/patients-visitors/portable-medical-profile/.

Medications for:____

Pharmacy Name: (used for prescriptions)___________________________________ Pharmacy Phone #:(_____)_______________

Name of medication	**Dose**	**When Do You Take This?**	**Physician that prescribed or Over the Counter**	**Why do you take this?**	**Potential side effects to watch for:**	**What does the pill look like? Injection?**

Immunizations	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date

Date this profile was last updated:_________________________

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