Marshfield Clinic
Health System

Portable Health Profile Record

Name _____ DOB _____ Emergency contact (name/phone) _____

Do you have a living well: ☐ Yes ☐ No 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 Provider

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	Level of assist and/or equipment needed
Basic self care	☐ Yes ☐ No	
Recreation/Play/Leisure	☐ Yes ☐ No	
Feeding/Swallowing	☐ Yes ☐ No	
Walking up/down stairs	☐ Yes ☐ No	
Walking in your house	☐ Yes ☐ No	
Community access (church, store, school etc.)	☐ Yes ☐ No	
Vision and hearing	☐ Yes ☐ No	

Equipment and Devices Used

Equipment description	Vendor and contact number	Date of last service

Orthotics or Prosthetics Information

Component description	Provider	Date of last service

https://www.marshfieldclinic.org/locations/marshfield-medical-center/inpatient-rehabilitation

Medications for _____

Pharmacy name (used for prescription) _____ 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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