



Casia Street #10
San Juan, Puerto Rico 00921

Telephone:
787-641-7582

Toll free number
1-800-449-8729

Health Profile



Name: _____

Birth Date: _____



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Important Note:

The information in this document is strictly confidential. If found, please, return to owner.

Courtesy of the Comprehensive Intensive Integrated Rehabilitation Program (CIIRP), VA Caribbean Healthcare System, P.R.

(Revised 2012)



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(Revised 2012)

Web Sites

www.vagov.com
www.MyHealtheVet.com
www.amputee-coalition.org

Community Contacts:
Office of Elderly Affairs
(Ombudsman)
787-725-9788

Department of Family
(Social Emergency)
787-749-1333

Emergency
911



This booklet is provided for your use when you visit your doctor or during a medical emergency.

Date originally completed

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IX. IMPORTANT RESOURCES:

VA Tele-Health

787-641-7582 ext. 75865
1-877-737-8820

VA Pharmacy

787-641-7582 ext. 31182
1-877-737-8820

Suicide Prevention Line

(Veterans Hospital)
787-622-4822
1-866-712-4822

Suicide Prevention National Hotline

1-800-273-8255

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Suicide Prevention National Hotline

1-800-273-8255

X. NON-PRESCRIBED MEDICATIONS:

List health products/supplements currently in use and its purpose.

Medication	Dose	Frequency
Name:		
Use:		
Name:		
Use:		
Name:		
Use:		
Name:		
Use:		
Name:		
Use:		

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X. NON-PRESCRIBED MEDICATIONS:

List health products/supplements currently in use and its purpose.

Medication	Dose	Frequency
Name:		
Use:		
Name:		
Use:		
Name:		
Use:		
Name:		
Use:		
Name:		
Use:		

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I. Contact Information

Home Address: _____

Postal Address: _____

Tel. _____ Cel. _____

A. Caregiver:

Name: _____

Relationship: _____

Tel. _____ Cel. _____

Alternate person: _____

Relationship: _____

Tel. _____ Cel. _____

VIII. PRESCRIBED MEDICATIONS:

Name medications currently in use:

Medication	Dose	Frequency
Name: _____ Use: _____		

I. Contact Information

Home Address: _____

Postal Address: _____

Tel. _____ Cel. _____

A. Caregiver:

Name: _____

Relationship: _____

Tel. _____ Cel. _____

Alternate person: _____

Relationship: _____

Tel. _____ Cel. _____

VIII. PRESCRIBED MEDICATIONS:

Name medications currently in use:

Medication	Dose	Frequency
Name: _____ Use: _____		

VIII. MEDICAL HISTORY:

Mention important medical procedures, surgeries and hospitalizations:

Procedure	Year	Hospital

B. Do you have a designated person to make your health care or medical decisions?

Yes No

Name: _____

Relationship: _____

Tel. _____ Cel. _____

Alternate person: _____

Relationship: _____

Tel. _____ Cel. _____

C. Emergency Contacts:

Name: _____

Relationship: _____

Tel. _____ Cel. _____

Name: _____

Relationship: _____

Tel. _____ Cel. _____

VIII. MEDICAL HISTORY:

Mention important medical procedures, surgeries and hospitalizations:

Procedure	Year	Hospital

B. Do you have a designated person to make your health care or medical decisions?

Yes No

Name: _____

Relationship: _____

Tel. _____ Cel. _____

Alternate person: _____

Relationship: _____

Tel. _____ Cel. _____

C. Emergency Contacts:

Name: _____

Relationship: _____

Tel. _____ Cel. _____

Name: _____

Relationship: _____

Tel. _____ Cel. _____

II. Preferred Hospital:

Name: _____

Address: _____

Telephone: _____

III. Health Insurance

1. Veterans Insurance []

Priority group number: _____

2. Primary Health Insurance:

Insurance number _____

3. Medicare: [] Part A [] Part B

[] Part C [] Part D

Medicare number _____

Specialty	Telephone
Foot Care Nurse:	
Prosthetist:	
Orthotist:	
VA Prosthetics Services	787-641-7582 Ext. 30217

II. Preferred Hospital:

Name: _____

Address: _____

Telephone: _____

III. Health Insurance

1. Veterans Insurance []

Priority group number: _____

2. Primary Health Insurance:

Insurance number _____

3. Medicare: [] Part A [] Part B

[] Part C [] Part D

Medicare number _____

Specialty	Telephone
Foot Care Nurse:	
Prosthetist:	
Orthotist:	
VA Prosthetics Services	787-641-7582 Ext. 30217

VII. SERVICE PROVIDERS:

Specialty	Telephone
Primary Social Worker:	787-641-7582 Ext.
Primary Care Physician:	787-641-7582 Ext.
Rehabilitation Physician:	787-641-7582 Ext.
Amputation Coordinator: Marilyn Rodríguez	787-641-7582 Ext. 11031
Rehab Ward Case Manager: Susan Ruiz	787-641-7582 Ext. 83126
Psychologist:	
Psychiatrist:	
Foot Care Nurse:	

4. Health Management

Organization (HMO) _____

HMO num. _____

5. Secondary health insurance

Insurance num. _____



VII. SERVICE PROVIDERS:

Specialty	Telephone
Primary Social Worker:	787-641-7582 Ext.
Primary Care Physician:	787-641-7582 Ext.
Rehabilitation Physician:	787-641-7582 Ext.
Amputation Coordinator: Marilyn Rodríguez	787-641-7582 Ext. 11031
Rehab Ward Case Manager: Susan Ruiz	787-641-7582 Ext. 83126
Psychologist:	
Psychiatrist:	
Foot Care Nurse:	

4. Health Management

Organization (HMO) _____

HMO num. _____

5. Secondary health insurance

Insurance num. _____



IV. MEDICAL CARE IN AN EMERGENCY

A. Advance Directives

1. Do I have Advance Directives?

Yes No

The document can be found:

2. I am an Organ Donor?

Yes No

B. Transfusions

Do I accept blood transfusions?

Yes No

Blood Type: _____

B. Prosthesis Device Services:

Prosthesis vendor	
Contact person	
Telephone	
History	
Service dates:	

IV. MEDICAL CARE IN AN EMERGENCY

A. Advance Directives

1. Do I have Advance Directives?

Yes No

The document can be found:

2. I am an Organ Donor?

Yes No

B. Transfusions

Do I accept blood transfusions?

Yes No

Blood Type: _____

B. Prosthesis Device Services:

Prosthesis vendor	
Contact person	
Telephone	
History	
Service dates:	

VI. Lower/Upper Limb Prosthesis:
[] I have a limb prosthesis.

A. Description

Level and side	
Type	Permanent ____ Temporary ____
Suspension type	
Socket type	
Interface (if needed—liners)	
Knee (if applicable)	
Foot	
Prosthetic socks— # of Ply's	
Other information	

VI. Lower/Upper Limb Prosthesis:
[] I have a limb prosthesis.

A. Description

Level and side	
Type	Permanent ____ Temporary ____
Suspension type	
Socket type	
Interface (if needed—liners)	
Knee (if applicable)	
Foot	
Prosthetic socks— # of Ply's	
Other information	

C. Allergies

List medications, foods, or other supplemental health products which cause you allergic reactions.

Medication (s)	Reaction
Food/Product (s)	Reaction

D. Immunizations Record:

Vaccine	Date
Influenza	
Pneumonia	
Hepatitis	
Other	

C. Allergies

List medications, foods, or other supplemental health products which cause you allergic reactions.

Medication (s)	Reaction
Food/Product (s)	Reaction

D. Immunizations Record:

Vaccine	Date
Influenza	
Pneumonia	
Hepatitis	
Other	

**E. Medical Conditions/Risk Factors
(Check all applicable)**

	Visual problems
	Do you wear glasses or contact lenses?
	Hearing problems
	Use Hearing Aids
	Speech difficulties
	Swallowing difficulties
	Diabetes
	High blood pressure
	Use of anticoagulants
	Cardiac problems
	Asthma
	Stroke

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**V. Orthotics Information:
(if applicable)**

Name of orthosis	
Date provided	
Area were used	
Side were used	
Purpose	
How to perform hygiene	
Vendor	
Contact person	
Telephone #	
History	
Service dates	
Service dates	
Service dates	

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**E. Medical Conditions/Risk Factors
(Check all applicable)**

	Visual problems
	Do you wear glasses or contact lenses?
	Hearing problems
	Use Hearing Aids
	Speech difficulties
	Swallowing difficulties
	Diabetes
	High blood pressure
	Use of anticoagulants
	Cardiac problems
	Asthma
	Stroke

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**V. Orthotics Information:
(if applicable)**

Name of orthosis	
Date provided	
Area were used	
Side were used	
Purpose	
How to perform hygiene	
Vendor	
Contact person	
Telephone #	
History	
Service dates	
Service dates	
Service dates	

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IV. Wheelchair Information:
(if applicable)

Type	
Date provided	
Vendor	
Contact person	
Telephone Number	
History	
Service dates	

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Continued: Medical Conditions/Risk Factors (Check all applicable)

	Dementia
	Head trauma
	Hepatitis A, B, or C
	Convulsions
	Substance abuse/use
	Depression
	Anxiety
	Cancer/Type:

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IV. Wheelchair Information:
(if applicable)

Type	
Date provided	
Vendor	
Contact person	
Telephone Number	
History	
Service dates	

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Continued: Medical Conditions/Risk Factors (Check all applicable)

	Dementia
	Head trauma
	Hepatitis A, B, or C
	Convulsions
	Substance abuse/use
	Depression
	Anxiety
	Cancer/Type:

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V. Functional Status and Use of Assistive Devices



A. I do my self care:

- Independently.
- With supervision for: _____
- With helper assistance for:

- Using the following assistive devices:

B. To move from one surface to the other:

- I am independent.
- I need supervision.
- I need assistance.
- Type of assistance: _____

C. To walk or move from one place to another:

- I walk independently.
- I walk with an assistive device:

- I walk with supervision.
- I walk with assistance.
- I use a manual wheelchair independently.
- I need assistance to propel my manual wheelchair.
- I use a motorized wheelchair.

D. Assistive Devices:

- Type of wheelchair: _____
- Type of walking device: _____

Date Provided: _____

V. Functional Status and Use of Assistive Devices



A. I do my self care:

- Independently.
- With supervision for: _____
- With helper assistance for:

- Using the following assistive devices:

B. To move from one surface to the other:

- I am independent.
- I need supervision.
- I need assistance.
- Type of assistance: _____

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- I walk with an assistive device:

- I walk with supervision.
- I walk with assistance.
- I use a manual wheelchair independently.
- I need assistance to propel my manual wheelchair.
- I use a motorized wheelchair.

D. Assistive Devices:

- Type of wheelchair: _____
- Type of walking device: _____

Date Provided: _____