Health Information

Personal and Confidetial

Last Name (as it appears in your passport):	**First Name**:	**Middle Initial**:

Home Phone:	**Mobile Phone**:	**Email**:

Gender: ☐ Male ☐ Female	**Height**:	**Weight**:	**Age**:	**Date of Birth**:

Dietary Needs: ☐ None ☐ Diabetic ☐ Low Sodium ☐ Gluten-Free ☐ Vegetarian ☐ Other:______________________

Allergies (Foods, Animals, Plants, Pollen, Insects)	**Reaction at Exposure** (ex. Hives, Fever, Rash, etc.)
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________
(If need more space please attach separate sheet)	(If need more space please attach separate sheet)

Mobility (Please note that manual & electric wheelchairs must be pre-approved by airlines before traveling):

___ Fully able to walk	___ Fully able to sit and stand	___ Fully able to bend and lift
___ Able to walk short distance	___ Sit/stand with limits/assistance	___ Bending and/or lifting restrictions
___ Able to go up/down stairs	___ Use of stairs with assistance	___ Use of stairs with limitations
___ Unable to walk	___ Unable to sit or stand	___ Unable to bend
___ Use a cane at home	___ Use a walker at home	___ Use a wheelchair at home
___ Use a manual wheelchair	___ Use a dry-cell motorized chair	___ Use a wet-cell motorized chair
___ Provide a wheelchair for me	___ Will bring my dry-cell chair	___ Will bring my wet-cell chair

Wheelchair Model: Weight: Folded Measurement: Length: Width: Height:

Durable Medical Equipment Use / Supplies (Please list all medications you will bring on pilgrimage and attach additional list, if needed):

___ None	___ Bi-Pap Machine	___ Diabetes Supplies
___ Feeding Pump	___ CPAP Machine	___ Syringes
___ Oxygen Concentrator	___ Nebulizer	___ Cane or Walker
___ Wound Care Dressings	___ Ostomy Appliances	___ Other:______________________

Details (ex. machine make and model):

Medications (Please list all medications you will bring on pilgrimage and attach additional list, if needed):

Drugs:	Dose/Frequency:	Reason for taking drug:
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Assistance needed with medication? ☐ No ☐ Yes

Does medication require refrigeration? ☐ No ☐ Yes

Hospitalité de Miami • 11291 SW 142nd Avenue • Miami, FL 33186 • hospitalitedemiami.org

Health Information

Personal and Confidetial

Health History - Please indicate whether you currently have or had in the past (include dates)

Current	Past	Condition	Current	Past	Condition	Current	Past	Condition
___	___	Abnormal Blood Pressure	___	___	Bladder Incontinence	___	___	Abuse Victim
___	___	Arthritis	___	___	Bleeding Disorder	___	___	Depression
___	___	Asthma	___	___	Blood-born (HIV, Hepatitis, etc.)	___	___	Eating Disorder
___	___	Eyesight Impairment	___	___	Bowel Incontinence	___	___	Fear of Enclosed Spaces/Crowds
___	___	Diabetes: Insulin Dependent	___	___	Cancer:______________________	___	___	Mental/Emotional Disorder
___	___	Diabetes: Non-insulin Dependent	___	___	Heart Disease	___	___	Nervous System Disorder
___	___	Dizziness	___	___	Intestinal Disorder	___	___	Post-traumatic Stress Disorder (PTSD)
___	___	Hearing Impairment	___	___	Musculoskeletal Disorder	___	___	Psychotherapy
___	___	Hernia	___	___	Open Wounds, Ulcers or Sores	___	___	Recent Loss of a Loved One
___	___	Nosebleeds	___	___	Respiratory Disorder:___________	___	___	Substance Abuse
___	___	Seizure Disorder	___	___	Spinal Injury, Surgery or Disease	___	___	Pregnant: Due Date:____________
___	___	Speech Impairment	___	___	Stroke	___	___	Pacemaker
___	___	Metal Plates	___	___	Other: (Celiac, Crohns, etc):________________________________			

Further describe conditions checked above: ☐ **acute** ☐ **chronic** ☐ **stable** ☐ **improving** ☐ **declining**

Date and reason last seen by physician:

Date and reason for surgeries/hospitalization:

Current therapies: ☐ none ☐ physical ☐ respiratory ☐ speech ☐ counseling ☐ Other:________________________

Care Needs:

____ No Assistance Needed	____ Assistance Eating	___ Assistance Bathing
____ Assistance Needed to Dress	____ Assistance Getting Up/Down	___ Assistance Toileting
____ Assistance with Medication	____ Assistance Turning at Night	___ Wound Dressing Assistance
____ Care Plan Prescribed by MD	____ Health Care Plan Attached	___ Other:______________________

Traveling: ☐ Alone ☐ with Relative ☐ with friend/campanion/caregiver | **Relationship:**

Co-traveler Name: | **Mobile Phone**:

Co-traveler to provide what assistance: ☐ all care needs ☐ some care needs ☐ None (Hospitalite de Miami to provide all care needs)

Health Care Proxy: (ex. DNR) concerning healthcare decisions: ☐ No ☐ Yes - ☐ Proxy copy attached

Primary Care Physician: | **Telephone**:

Address: | **City/State/Zipcode**

(not traveling with you)
Emergency Contact Person: | **Relationship**:

Home Phone: | **Mobile Phone**: | **Work Phone**:

Secondary Emergency Contact Person: | **Relationship**:

Home Phone: | **Mobile Phone**: | **Work Phone**: