

Beaumont

Beaumont Health

InterHealth® - HealthCare for International Travelers
3535 W. Thirteen Mile Rd., Suite 605
Royal Oak, MI 48073

Thank you for selecting InterHealth®: Health Care for International Travelers, Michigan's premier travel medicine service. We have provided counseling and care to more than 65,000 people.

Our office is located in the Beaumont Medical Office Building next to Beaumont Hospital, Royal Oak. Our address is 3535 West 13 Mile Road, Suite 605. It is most convenient to park in the North Parking Deck.

Please complete the two-page travel/medical profile for each person included in your appointment. These forms should be filled out as completely as possible including your itinerary in the order in which you will be traveling and with a complete vaccination history (to the best of your knowledge). After you return the completed forms to our office, we will promptly contact you to schedule an appointment. The travel consultation appointment includes a complete review of your itinerary, personal health history and immunization status to develop recommendations specific to your needs. You will receive our Traveler's Handbook and country specific printouts with English-speaking physicians (should medical problems arise overseas).

Please remember:

- List exact cities and "regions", including rural and urban areas. Please include a tour itinerary if applicable.
- List any current or previous health problems.
- List all medications or supplements and allergies that you take.

Bring any record of immunization or your "Yellow Book" (International Certificate of Vaccination) to the appointment.

Payment for travel consultations and immunizations, and all travel-related services are your responsibility and payment is expected at the time of service. We accept Visa, MasterCard, American Express, cash or check.

Please note: Our appointments run on time. Late arrivals may require rescheduling so that we are able to accommodate all of our patients in a timely way.

We look forward to serving your travel needs. If you have any questions, please do not hesitate to call our office at 248-551-0495, option 1.

Sincerely,

Jeffrey D. Band, M.D.
Medical Director

Beaumont

InterHealth®

Health Care for International Travelers

Medical Office Building
3535 W. 13 Mile Road, Suite 605
Royal Oak, Michigan 48073
248-551-0495
Fax: 248-551-7268
E-mail: interhealth@beaumont.org

TRAVELER'S INFORMATION

Please print

Name _____
LAST FIRST

Address _____

City _____ State _____ Zip _____

Phone _____

Date of Birth _____ Age _____ Sex _____

Place of Birth _____

Marital Status _____ Maiden Name _____

Are you a past InterHealth patient? Yes No

How did you hear about us?
 Former client Friend Doctor

Travel agent Other _____

PURPOSE OF TRAVEL

Business Pleasure Missionary Study Other

Person to be notified in case of emergency:

Name _____ Phone () _____

Address _____

City _____ State _____ Zip _____

Relationship _____

Personal Physician:

Name _____

Address _____

City _____ State _____ Zip _____

Phone () _____

Employer:

Name _____ Phone () _____

Address _____

City _____ State _____ Zip _____

TRAVEL ITINERARY

Please list in order ALL countries and cities you will visit, land in, or travel through.

Date of departure _____

Date of return _____

Date	Country	City
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Type of travel: please check all that apply to your trip

Hotels

Staying with family

Cruise Ship

Safari

PATIENT MEDICAL PROFILE

Name _____

Indicate date(s) of vaccine or year of disease:

Yes	No	Mo/Yr	Yes	No	Mo/Yr
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus series	<input type="checkbox"/>	<input type="checkbox"/>	Meningococcus
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus booster	<input type="checkbox"/>	<input type="checkbox"/>	Rabies
<input type="checkbox"/>	<input type="checkbox"/>	Tdap (adults)	<input type="checkbox"/>	<input type="checkbox"/>	Zoster/shingles
<input type="checkbox"/>	<input type="checkbox"/>	DTaP (children)	<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox
<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	Influenza
<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Japanese encephalitis
<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Yellow fever
<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcus
<input type="checkbox"/>	<input type="checkbox"/>	Hib	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	TB skin test
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Other

Current Medications: (Prescription and non prescription)

Medication	Dosage	When Started	Medical Reason

Pediatric Patients (Under 18 years old)

Weight: _____

Females Only

Date of last menstrual period _____

- I am not pregnant
 I might be pregnant

Are you breast-feeding? Yes No

Allergies and Sensitivities:

Yes	No	Antibiotics	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	Egg allergy
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Cephalosporins	<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever
<input type="checkbox"/>	<input type="checkbox"/>	Vaccines	<input type="checkbox"/>	<input type="checkbox"/>	Insect allergy
<input type="checkbox"/>	<input type="checkbox"/>	Antitoxins	<input type="checkbox"/>	<input type="checkbox"/>	Skin allergy
<input type="checkbox"/>	<input type="checkbox"/>	Neomycin	<input type="checkbox"/>	<input type="checkbox"/>	Photosensitivity (sunlight)
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Active Medical Problems:

I have **NO** medical problems

I **have** or **have had** the following medical conditions:

- | | |
|---|---|
| <input type="checkbox"/> Anaphylactic reaction | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Emphysema or chronic bronchitis |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Chronic kidney disease |
| <input type="checkbox"/> Pacemaker/ICD | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Psychiatric disorder |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Immune disorder |
| <input type="checkbox"/> Retinal disease | <input type="checkbox"/> Inflammatory disorder |
| <input type="checkbox"/> Insulin requiring diabetes | <input type="checkbox"/> Spleen removed |
| <input type="checkbox"/> Elevated cholesterol | <input type="checkbox"/> Malignancy/Cancer in past 10 yrs |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Special handicap/challenge |
| <input type="checkbox"/> Hemolytic anemia | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Epilepsy or seizures | _____ |
| <input type="checkbox"/> Motion sickness | _____ |
| <input type="checkbox"/> Vertigo | |

Significant Surgeries:
