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

PHARMACY INFORMATION

Name_____

Street & City_____

Phone_____

Type of Accomodations: *(please check all that apply to your trip)*

Hotels Staying with family

Cruise Ship Safari

Other _____

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PATIENT MEDICAL PROFILE

Name _____

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

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

Current Medications: (*Prescription and non prescription*)

Medication	Dosage	When Started	Medical Reason

Pediatric Patients (*Under 18 years old*)

Weight: _____

Female Patients

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	
☐	☐	Sulfa	☐	☐	Egg allergy
☐	☐	Penicillin	☐	☐	Asthma
☐	☐	Cephalosporins	☐	☐	Hives
☐	☐	Tetracycline	☐	☐	Hay fever
☐	☐	Vaccines	☐	☐	Insect allergy
		_____	☐	☐	Skin allergy
☐	☐	Antitoxins	☐	☐	Photosensitivity (sunlight)
		_____			
☐	☐	Neomycin	☐	☐	Other:_____

Active Medical Problems:

☐ **I have NO medical problems**

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

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

Significant Surgeries:

_____

_____

_____

_____

_____

_____