

Beaumont

InterHealth[®]

Health Care for International Travelers

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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 Accommodations: (please check all that apply to your trip)

Hotels Staying with family

Cruise Ship Safari

Other _____

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: _____

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	
<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"/>	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:
