corewellhealth.org

InterHealth – Healthcare for International Travelers
William Beaumont University Hospital Royal Oak
Corewell Health East

3535 W. Thirteen Mile Rd., Suite 605
Royal Oak, MI 48073

Thank you for your interest in InterHealth. Please complete the two-page travel/medical profile for each person included in your appointment. Please email or fax the completed forms to the office as indicated below. Once received, we will contact you to schedule the appointment.

If available, please include or bring any record of immunization and/or your "Yellow Book" (international Certificate of Vaccination) to the appointment.

Our office is in the Medical Office Building on the campus of William Beaumont University Hospital - Royal Oak. Our address is 3535 West 13 Mile Rd., Suite 605. It is most convenient to park in the North Parking Deck.

We DO NOT bill any insurance. Payment for your visit, including consultation and immunizations, are your responsibility and payment is expected at the time of service. We accept Visa, MasterCard, American Express, cash or check.

We look forward to serving you. If you have questions, please do not hesitate to call our office at 248-551-0495.

Please return these forms to the email address below:
cheinterhealth@corewellhealth.org

or mail to:
InterHealth
Medical Office Building - Royal Oak
3535 W. 13 Mile Rd., Suite 605
Royal Oak, MI 48073
Phone: 248-551-0495 **Fax: 248-551-7268**

InterHealth—Travel Medicine
Medical Office Building
3535 W. Thirteen Mil Rd, Ste 605
Royal Oak, MI 48073
Email: CHEInterHealthInterHealth@corewellhealth.org

TRAVELER'S INFORMATION

Please print

Name_______________________________________
Last First

Address_______________________________________

City____________________ State________ Zip__________

Phone_______________________________________

Date of Birth______________ Age______ Sex__________

Place of Birth______________ Marital Status__________

Email_______________________________________

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 an emergency:

Name______________ Phone #__________________

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 will travel through

Date of departure__________________________

Date of return__________________________

Date	Country	City

PHARMACY INFORMATION

Name__________________________

Street and City__________________________

Phone #__________________________

Type of Accommodations: (*please check all that apply*)

Hotels Staying with family

Cruise Ship Safari Dorms

Airbnb Mission Housing

Corewell Health™

PATIENT MEDICAL PROFILE

Name ______________________________

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

Yes	No		Mo/Yr
☐	☐	Tetanus series	______
☐	☐	Tetanus booster	______
☐	☐	Tdap (adults)	______
☐	☐	DTaP (children)	______
☐	☐	Polio	______
☐	☐	Measles	______
☐	☐	Mumps	______
☐	☐	German measles	______
☐	☐	Hib	______
☐	☐	Hepatitis A	______
☐	☐	Hepatitis B	______

Yes	No		Mo/Yr
☐	☐	Meningococcus	______
☐	☐	Rabies	______
☐	☐	Zoster/shingles	______
☐	☐	Chicken pox	______
☐	☐	Influenza	______
☐	☐	Japanese encephalitis	______
☐	☐	Yellow fever	______
☐	☐	Pneumococcus	______
☐	☐	Typhoid	______
☐	☐	TB skin test	______
☐	☐	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
☐	☐	Sulfa
☐	☐	Penicillin
☐	☐	Cephalosporins
☐	☐	Tetracycline
☐	☐	Vaccines
		______________
☐	☐	Antitoxins
		______________
☐	☐	Neomycin

Yes	No	
☐	☐	Egg allergy
☐	☐	Asthma
☐	☐	Hives
☐	☐	Hay fever
☐	☐	Insect allergy
☐	☐	Skin allergy
☐	☐	Photosensitivity (sunlight)
☐	☐	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:

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