

	NAAF MARINE SERVICES	NMS/F-04	Date	1 July 2012
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	TITLE:- PRE-JOINING MEDICAL EXAMINATION REPORT/CERTIFICATE		Issue No	00
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Appendix 1
Medical Exam Form
CONFIDENTIAL FORM

Name (last, first, middle): RASHID, MD MAMUNUR

Date of birth (day/month/year): 06 / 03 / 1983 Sex: ☒ male ☐ female

Home address: CHARKIDIRPUR, WARD NO-09, BOALKHALI,
GOMDOND-4366, CHATTGRAM

Passport No./Discharge Book No.: A0023266X, T/33118

Department (deck/engine/radio/food handling/other): ETR (ENGINE)

Type of ship: Multi-Purpose cargo/Container/Bulk Carrier/Tanker (Oil/Product/Chemical/Crude)

Trade area: Worldwide

Examinee's personal declaration

(Assistance should be offered by medical staff)

Have you ever had any of the following conditions:

Condition	Yes	No	Condition	Yes	No
1. Eye/vision problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	19. Do you smoke, use	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. High blood pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	alcohol or drugs		
3. Heart/vascular disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	20. Operation/surgery	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Heart surgery	<input type="checkbox"/>	<input checked="" type="checkbox"/>	21. Epilepsy/seizures	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Varicose veins/piles	<input type="checkbox"/>	<input checked="" type="checkbox"/>	22. Dizziness/fainting	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Asthma/bronchitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	23. Loss of consciousness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Blood disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	24. Psychiatric problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	25. Depression	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Thyroid problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	26. Attempted suicide	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Digestive disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	27. Loss of memory	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Kidney problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	28. Balance problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. Skin problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	29. Severe headaches	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13. Allergies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	30. Ear (hearing/tinnitus)/	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14. Infectious/contagious diseases	<input type="checkbox"/>	<input checked="" type="checkbox"/>	nose/throat problems		
15. Hernia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	31. Restricted mobility	<input type="checkbox"/>	<input checked="" type="checkbox"/>
16. Genital disorders	<input type="checkbox"/>	<input checked="" type="checkbox"/>	32. Back or joint problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>
17. Pregnancy <u>N/A</u>	<input type="checkbox"/>	<input type="checkbox"/>	33. Amputation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
18. Sleep problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	34. Fractures/dislocations	<input type="checkbox"/>	<input checked="" type="checkbox"/>

If any of the above questions were answered "yes," please give details.

(CONTROLLED DOCUMENT)