

13.	Allergies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	24.	Attempted suicide	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14.	Infectious/contagious diseases	<input type="checkbox"/>	<input checked="" type="checkbox"/>	25.	Loss of memory	<input type="checkbox"/>	<input checked="" type="checkbox"/>
15.	Hernia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	26.	Balance problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
16.	Genital disorders	<input type="checkbox"/>	<input checked="" type="checkbox"/>	27.	Severe headaches	<input type="checkbox"/>	<input checked="" type="checkbox"/>
17.	Pregnancy <i>N/A</i>	<input type="checkbox"/>	<input type="checkbox"/>	28.	Ear (hearing/ tinnitus) nose/throat problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
18.	Do you smoke, use alcohol or drugs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	29.	Depression	<input type="checkbox"/>	<input checked="" type="checkbox"/>
19.	Operation/surgery	<input type="checkbox"/>	<input checked="" type="checkbox"/>	30.	Restricted mobility	<input type="checkbox"/>	<input checked="" type="checkbox"/>
20.	Epilepsy/ seizures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	31.	Back or joint problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
21.	Dizziness/fainting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	32.	Amputation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
22.	Loss of consciousness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	33.	Fractures/dislocation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
23.	Psychiatric problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	34.	Sleep problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

		YES	NO
Additional questions			
35.	Have you ever been signed off as sick or repatriated from a ship?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
36.	Have you ever been hospitalized?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
37.	Have you ever been declared unfit for sea duty?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
38.	Has your medical certificate ever been restricted or revoked?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
39.	Are you aware that you have any medical problems, diseases or illness?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
40.	Do you feel healthy and fit to perform the duties of your designed position / occupation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
41.	Are you allergic to any medication?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Comments:

Fit For Duty on Board Ship

		YES	NO
Additional questions			
42.	Are you taking any non-prescription or prescription medications?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

If yes, please list the medications taken and the purpose(s) and dosage(s).