



AMERICAN CLUB MEDICAL HISTORY QUESTIONNAIRE—2019

IMPORTANT: This medical history form must be completed in the presence of the clinician physician.

American Club Hologram Sticker No. (from previous page): _____
 Doctor's Initials: _____



Name: ROUF Last Name ABDUR First Name Middle Name

Home Address: VTP; JHITKA, P/S; HORIRAMPUR, DIST. MAJLIGONJ

Date of Birth (dd/mm/yyyy): 30.10.1980 Phone No.: 01787625981 Seaman's Certificate No.: 21019916 Employer: WANGUARD MARITIME

In case of emergency, notify: _____ Relationship: _____ Address: _____ Phone No.: _____

[Signature]
 Seafarer's Signature

Personal Physician or Clinic: _____ Physician's Phone No.: 02-333313678
 Address: _____

Family History					
	YES	NO		YES	NO
Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Epilepsy/Seizure	<input type="checkbox"/>	<input checked="" type="checkbox"/>

If "YES" to any of the above, please explain: _____
 Any other major medical or physical conditions? _____

MALE ONLY	YES	NO	FEMALE ONLY	YES	NO
Prostate Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Testicular Lumps	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Breast Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Penile Discharge	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Menstrual Issues	<input type="checkbox"/>	<input type="checkbox"/>

If "YES" to any of the above, please explain: _____

Are you currently under a doctor's care? YES NO
 If "YES", for what problem(s)? _____
 Physician's name and address (if different from the one noted above) _____
 Have you had surgeries or have been hospitalized? YES NO
 If "YES", provide the date(s) and give details below: _____

Date of last Tetanus vaccination: _____ (dd/mm/yyyy)
 List other vaccinations/dates: _____ (dd/mm/yyyy)
 Date of last dental cleaning: _____ (dd/mm/yyyy)
 Date of any recent dental work: _____ (dd/mm/yyyy)

Overall, would you say that your health is (please check only one):
 Excellent Good Fair

Have you received treatment for the following?					
	YES	NO		YES	NO
Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Jaundice or Hepatitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Slipped Disk	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Wrist Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Fractured Vertebrae	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Rash or Skin Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hernia/Hydrocele	<input type="checkbox"/>	<input checked="" type="checkbox"/>
20/20 Vision	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Epilepsy/Seizure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Drug Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental Breakdown	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Psychological Impairment, Depression or Mental Illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Sexually Transmitted Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>			

Allergies YES NO
 Do you have any allergies? YES NO
 If you have allergies, please describe: _____

	YES	NO	
Do you smoke?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", how long? If "YES", how many packs per day?
Do you drink alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", how much and how often?
Do you use or take any drugs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", name the drugs and how often used?

Are you presently on any medication(s)? YES NO
 If "YES", please list prescription and over the counter medications you take regularly: _____

Fit For Duty on Board Ship

DECLARATION
 I, ABDUR ROUF, Seaman's Number 21019916, Hereby Declare that I have made full disclosure of all of my medical history to the Doctors and staff of this Clinic. I am aware that the information supplied by forms the basis upon which I will be offered employment as a Seafarer. I understand that in the event of any misrepresentation either by statement or omission I will lose the right to benefit from sick pay and / or compensation which would otherwise be due under the Contract of Employment or under any Collective Bargaining Agreement. I Also Hereby consent to my medical records being made available upon demand to my employers and/or the Owners and/or Insurance of the Vessel or their authorized representatives.