AMERICAN CLUB MEDICAL HISTORY QUESTIONNAIRE—2019

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

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

Name:	AKBOR.	ALI	
	Last Name	**First Name**	**Middle Name**
Home Address:	SOZADUR. BORROB CHOWDHURY HAT. SONAGAZI RENI.		
Date of Birth (dd/mm/yyyy)	**Phone No.**	**Seaman's Certificate No.**	**Employer**
27-09-2003		T/ 34187.	VANGUARD MARITIME.
In case of emergency, notify:		**Relationship:**	
Address:		**Phone No.:**	

Seafarer's Signature

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

Family History

	YES	NO		YES	NO
Diabetes	☐	☑	Cancer	☐	☑
High Blood Pressure	☐	☑	Mental Illness	☐	☑
Heart Disease	☐	☑	Epilepsy/Seizure	☐	☑

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	☐	☑	Pregnancy	☐	☐
Testicular Lumps	☐	☑	Breast Lumps	☐	☐
Penile Discharge	☐	☑	Menstrual Issues	☐	☐

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

	YES	NO
Are you currently under a doctor's care?	☐	☑
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?	☐	☑
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	☐	☑	Jaundice or Hepatitis	☐	☑
Heart Trouble	☐	☑	Dizziness	☐	☑
High Blood Pressure	☐	☑	Back Problems	☐	☑
Shortness of Breath	☐	☑	Slipped Disk	☐	☑
Chest Pain	☐	☑	Wrist Problems	☐	☑
Chronic Cough	☐	☑	Fractured Vertebrae	☐	☑
Asthma	☐	☑	Arthritis/Gout	☐	☑
Tuberculosis	☐	☑	Kidney Problems	☐	☑
Rheumatic Fever	☐	☑	Cancer/Tumor	☐	☑
Frequent Headaches	☐	☑	Rash or Skin Problems	☐	☑
Vision Problems	☐	☑	Hernia/Hydrocele	☐	☑
20/20 Vision	☐	☑	Varicose Veins	☐	☑
Epilepsy/Seizure	☐	☑	Drug Problems	☐	☑
Hearing Problems	☐	☑	Mental Breakdown	☐	☑
Psychological Impairment, Depression or Mental Illness				☐	☑
Sexually Transmitted Disease				☐	☑

Allergies	YES	NO
Do you have any allergies?	☐	☑

If you have allergies, please describe: _____

	YES	NO	
Do you smoke?	☐	☑	If "YES", how long?
			If "YES", how many packs per day?
Do you drink alcohol?	☐	☑	If "YES", how much and how often:
Do you use or take any drugs?	☐	☑	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:				

DECLARATION

I, ALI AKBAR., Seaman's Number T/34187., **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.

Fit For Duty on Board Ship