AMERICAN CLUB MEDICAL HISTORY QUESTIONNAIRE—2019

THE AMERICAN CLUB 1917

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

American Club Hologram Sticker No. (from previous page):__________

Doctor's Initials: __________

Approved by Department of Shipping, Dr. M. Ayubur Rahman, MLO 20.., Govt. of the People's Republic of Bangladesh

Name:	HOSSAIN	DELOWAR	—
	Last Name	First Name	Middle Name
Home Address:	CHARHAZARI, COMPANIGANJ, NOAKHALI,		

Delowar

Seafarer's Signature

Date of Birth (dd/mm/yyyy)	Phone No.	Seaman's Certificate No.	Employer
03-06-1997		T/34659	VANGUARD MARITIME.

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

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, DELOWAR HOSSAIN, Seaman's Number T/34659, **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