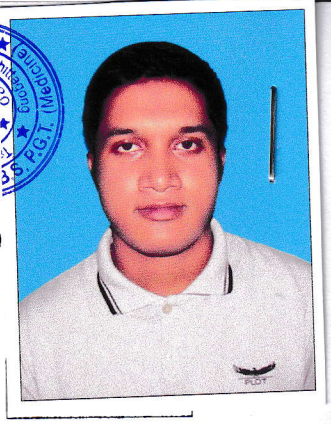

DR. M. AYUBUR RAHMAN ... M.B.B.S. P.G.T. (Medicine)

VANGUARD MARITIME LIMITED
MEDICAL HISTORY QUESTIONNAIRE

Dr.'s Initials

Name:	FAYAL AHAMED	Date of Birth :	23.05.2000
Address :	DARHIRMIDDUR. CHAKBAIL. TOIL, 2001, JAMALPUR		
	Seaman Certificate No.: T/34849	Phone :	01643979951
Employer :	Vessel : GREAROYAL	Job Title :	2/COOK
In Emergency, Notify :	Relationship :	Ph. :	
Personal Physician or Clinic :			
Address :			
	Physician's Phone :	02333313678	

Date : 25-07-23

ALLERGIES:

Family History Has anyone in your family ever had :

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☑	Heart Disease	☐	☑	Mental Illness	☐	☑
High Blood Pressure	☐	☑	Cancer	☐	☑	Epilepsy/Seizure	☐	☑

If "Yes", to any of the above, please explain:

Any other major conditions?

MALES ONLY	Yes	No	If yes, give details :	FEMALES ONLY	Yes	No
Prostate Problems	☐	☑		Pregnancy	☐	☐
Testicular Lumps	☐	☑		Breast Lumps	☐	☐
Penile Discharge	☐	☑		Menstrual Problems	☐	☐

Are you currently under a doctor's care? ☐ Yes ☑ No

If Yes, for what problem(s)?

Physician(s) Name/Address (if different than noted on page 1):

History of surgeries/hospitalizations : ☐ Yes ☑ No Date :

If yes, give details :

Date of last tetanus Vaccination:		(dd/mm/yyyy)
Other Vaccinations . Mention :		
Date of last dental cleaning:		(dd/mm/yyyy)
Date of recent dental work:		(dd/mm/yyyy)

Do you have or have 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 Disc	☐	☑
Chest Pain	☐	☑	Wrist Problems	☐	☑
Chronic Cough	☐	☑	Fractured Vertebrae	☐	☑
Asthma	☐	☑	Arthritis / Gout	☐	☑
Tuberculosis	☐	☑	Kidney Problems	☐	☑
Rheumatic Fever	☐	☑	Cancer / Tumor	☐	☑
Frequent Headaches	☐	☑	Rash or Skin Problem	☐	☑
Vision Problems	☐	☑	Hernia / Hydrocele	☐	☑
20/20 Vision	☐	☑	Varicose Veins	☐	☑
Epilepsy	☐	☑	Drug Problems	☐	☑
Hearing Problems	☐	☑	Mental Breakdown	☐	☑
Psychological Impairment, Depression or Mental Illness				☐	☑
Sexually Transmitted Disease				☐	☑

	Yes	No		
Do you or did you smoke?	☐	☑	How long?	
			Packs per day?	
Do you use alcoholic beverages?	☐	☑	How much/often?	
Do you use or take any drugs?	☐	☑	Mention drugs used below :	

Are you presently on any medication : ☐ Yes ☑ No

If yes, Please list prescription and over the counter medications you take regularly:

Would you say that your health is (please check one): ☐ Excellent ☑ Good ☐ Fair

DECLARATION

I, FAYSAL AHAMED, Seaman's Number T/34849, **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.