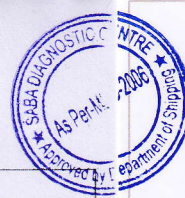


VANGUARD MARITIME LIMITED  
MEDICAL HISTORY QUESTIONNAIRE



Dr.'s Initials

Name: MAHMUDUL HASAN CHOWDHURY Date of Birth: 01-01-1994  
 Address: V. Dattapara, P- Dattapara P.S- CHONDROPORE Di- LAKSHMIPUR  
 Seaman Certificate No.: \_\_\_\_\_ Phone: 01622528881  
 Employer: \_\_\_\_\_ Vessel: Green Royal Job Title: 3E  
 In Emergency, Notify: Sabbirullah Chowdhury Relationship: Father Ph.: 01711786621  
 Personal Physician or Clinic: \_\_\_\_\_  
 Address: \_\_\_\_\_ Physician's Phone: 02-333313678

mahmud  
Date: 02-09-2023

ALLERGIES: \_\_\_\_\_

Family History Has anyone in your family ever had :

	Yes		No		Yes		No	
	Yes	No	Yes	No	Yes	No	Yes	No
Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Cancer	<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 conditions?  
 \_\_\_\_\_

MALES ONLY			If yes, give details :	FEMALES ONLY		
Yes	No	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 Problems	<input type="checkbox"/>	<input type="checkbox"/>	

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	<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 Disc	<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 Problem	<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	<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"/>			

	Yes	No	
Do you or did you smoke?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	How long?
			Packs per day?
Do you use alcoholic beverages?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	How much/often?
Do you use or take any drugs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	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, MAHMUDUL HASAN CHOWDHURY - 0107548, Seaman's Number \_\_\_\_\_, 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.