VANGUARD MARITIME LIMITED
MEDICAL HISTORY QUESTIONNAIRE

DR. M. AYUBUR RAHMAN M.B.B.S, P.G.T. (Medicine) Chamber: 10 Agrabad C/A, Chattogram

Dr.'s Initials

Name: MASUDUR RAHMAN		Date of Birth : 01/02/1976	
Address : 93/11/23, KAZLA, JATRABARI, DHAKA			
	Seaman Certificate No.:	Phone : 01819330277	
Employer : VANGUARD	Vessel : MV. BRAVE ROYAL	Job Title :	
In Emergency, Notify : MRS. JENIA FARDUSHY	Relationship : WIFE	Ph. : 01730266358	
Personal Physician or Clinic :			
Address : 93/11/23, KAZLA NOTUR RASTA MOOR, JATRABARI.			
	Physician's Phone :		

Seafarer's Signature [signature]

Date : 16 SEP 2021

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 :

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				☐	☑

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)**

	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, MASUDUR RAHMAN, Seaman's Number C/O/5995, **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.