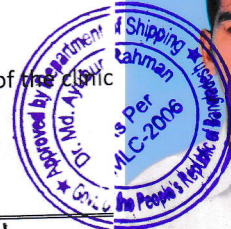




AMERICAN CLUB MEDICAL HISTORY QUESTIONNAIRE—2019

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

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



Name:	<u>KADER</u>	<u>MD</u>	<u>ALAUDDIN</u>
	Last Name	First Name	Middle Name
Home Address:	<u>PLOT NO- 15/16, BIJOY NAGAR, BLOCK-B, AIRPORT</u> <u>ALOS, PATENGA, CHATTOGRAM.</u>		
Date of Birth (dd/mm/yyyy)	Phone No.	Seaman's Certificate No.	Employer
<u>03-06-1999</u>	<u>01400171573</u>	<u>T/35357</u>	<u>VANGUARD MARITIME</u>
In case of emergency, notify:	Relationship:		Phone No.:
Address:			

✓
Alauddin

Seafarer's Signature

Personal Physician or Clinic:	Physician's Phone No.:	<u>02-333313678</u>
Address:		

Family History					
	YES	NO		YES	NO
Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart Disease	<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 medical or physical conditions? _____

MALE ONLY	YES	NO	FEMALE ONLY	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 Issues	<input type="checkbox"/>	<input type="checkbox"/>

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

Are you currently under a doctor's care?	YES	NO
	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	YES	NO
	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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	<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 Disk	<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 Problems	<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/Seizure	<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"/>			

Allergies	YES	NO
Do you have any allergies?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If you have allergies, please describe:		

	YES	NO	
Do you smoke?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", how long?
			If "YES", how many packs per day?
Do you drink alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", how much and how often?
Do you use or take any drugs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", name the drugs and how often used:

Are you presently on any medication(s)?	YES	NO
	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If "YES", please list prescription and over the counter medications you take regularly:		

DECLARATION
 I, MD ALAUDDIN KADER, Seaman's Number T/35357, 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