



**AMERICAN CLUB
MEDICAL HISTORY QUESTIONNAIRE**

Hologram Sticker No. _____

Dr.'s Initials _____



Name: M.D. IMRAN Date of Birth: _____
 Address: DASILE KHONDHUPARA, BANDAR, BANABUR, CHATTOGRAM
 Seaman Certificate No.: T/35431 Phone: 01825696531
 Employer: _____ Vessel: MY ROYAL IMAGE Title: TR. 6/L
 In Emergency, Notify: _____ Relationship: _____ Ph.: _____
 Personal Physician or Clinic: _____
 Address: _____ Physician's Phone: 0253313678

Date: _____

Imran 17 SEP 2023

ALLERGIES: _____

Do you have or have received treatment for the following:

Family History		Has anyone in your family ever had :	
	Yes	No	
Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart Disease
High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Cancer
			Mental Illness
			Epilepsy/Seizure

	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"/>

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"/>
Testicular Lumps	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Breast Lumps	<input type="checkbox"/>
Penile Discharge	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Menstrual Problems	<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)

	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

M.D. IMRAN, Seaman's Number T/35431, 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.