

Date of last tetanus shot: \_\_\_\_\_ (dd/mm/yyyy)  
Date of last dental cleaning: \_\_\_\_\_ (dd/mm/yyyy)  
Date of recent dental work: \_\_\_\_\_ (dd/mm/yyyy)

FEMALES ONLY

Pregnancy  Yes                      Menstrual Problems  Yes  
Breast Lumps  Yes

MALES ONLY

Prostate Problems  Yes                      Penile Discharge  Yes  
Testicular Lumps  Yes

Are you currently under a doctor's care? NO  
If Yes, for what problem(s)? \_\_\_\_\_  
Physician(s) Name/Address (if different than noted on page 1): \_\_\_\_\_  
Please list any surgeries/hospitalizations (reason for and date): NO

HABITS

Do you or did you smoke? NO How long? \_\_\_\_\_ Packs per day? \_\_\_\_\_  
Do you use alcoholic beverages? NO How much/often? \_\_\_\_\_  
Do you use or take any drugs? NO What kinds? \_\_\_\_\_

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

MD. MOJIBUR RAHMAN - KHAN - 0002188, Seaman's Number 0002188, 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 Insurers of the Vessel or their authorized representatives.