



**AMERICAN CLUB  
MEDICAL HISTORY QUESTIONNAIRE**



Hologram Sticker No. \_\_\_\_\_

Dr.'s Initials \_\_\_\_\_



Name: MD AL AMIN SUMON Date of Birth: 02/08/1988  
 Address: KASHID VILLA, HAZI ISLAMIA BRICKFIELD; ROAD No-18  
CHOTOPLE, AGRABAD Seaman Certificate No.: C/014737 Phone: 01717538129  
 Employer: \_\_\_\_\_ Vessel: ROYAL IMAGE Job Title: CH. OFFICER  
 In Emergency, Notify: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph.: \_\_\_\_\_  
 Personal Physician or Clinic: \_\_\_\_\_  
 Address: \_\_\_\_\_ Physician's Phone: 02333376678

Date: 16.09.2023

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

**Family History** Has anyone in your family ever had :

	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?  
 \_\_\_\_\_

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"/>			

MALES ONLY		If yes, give details :	FEMALES ONLY	
Yes	No		Yes	No
Prostate Problems	<input type="checkbox"/>		Pregnancy	<input type="checkbox"/>
Testicular Lumps	<input type="checkbox"/>		Breast Lumps	<input type="checkbox"/>
Penile Discharge	<input 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**  
MDACAMIN SUMON, Seaman's Number C/014737, **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.