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

I, MD. ANWAR HOSSAIN, Seaman's Number T/34189, 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.



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