



**AMERICAN CLUB
MEDICAL HISTORY QUESTIONNAIRE**

Hologram Sticker No. _____

Dr.'s Initials _____



BAPPY

Name: MD BAPPY HOSSAIN Date of Birth: 29-10-2000
 Address: ZEGHOKIA, PARKER DOUG, NATOLE SPDM, NATOLE
 Seaman Certificate No.: 7134245 Phone: 0179290281
 Employer: _____ Vessel: ROYAL MARU Job Title: CS
 In Emergency, Notify: _____ Relationship: _____ Ph.: _____
 Personal Physician or Clinic: _____
 Address: _____ Physician's Phone: 0233331367

Date: **21 SEP 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?

| 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)

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"/> | | | |

| | 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
MD. BAPPY HOSSAIN, Seaman's Number 7134245, 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.