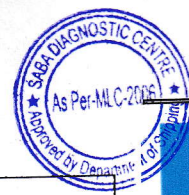


VANGUARD MARITIME LIMITED
MEDICAL HISTORY QUESTIONNAIRE



Dr.'s Initials



Seafarer's Signature

[Handwritten Signature]

Date: 01-10-23

Name: MD. MARUNOR RASHID Date of Birth: 05-07-2000
 Address: TOKINAGAR, PAKA, BARATIPAR, NARRE
 Seaman Certificate No.: TT32559 Phone: 01750 966015
 Employer: Vessel: GREAT ROYAL Job Title: DILER
 In Emergency, Notify: Relationship: Ph.:
 Personal Physician or Clinic:
 Address: Physician's Phone: 0253327367

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

Do you or did you smoke? Yes No How long? Paeks per day?
 Do you use alcoholic beverages? Yes No How much/often?
 Do you use or take any drugs? Yes No 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
 I, MD. MARUNOR RASHID, Seaman's Number TT32559, 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.