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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. SHAIF UDDIN, Seaman's Number C1078931, 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.



07-2023-1456