

VANGUARD MARITIME LIMITED  
MEDICAL HISTORY QUESTIONNAIRE

Dr.'s Initials

PHOTO

Name: <b>MD. WALID HOSSAIN SHAKIL</b>		Date of Birth: <b>02/08/1993</b>	
Address: <b>Hossain's CHINISPODR Gas office MODR, NARSINDI, DHAKA</b>		Seaman Certificate No.: <b>0107845</b>	
Employer:		Vessel: <b>BRAVE ROYAL</b>	Job Title: <b>2FE</b>
In Emergency, Notify: <b>MD. FARUK</b>		Relationship: <b>FATHER</b>	Ph.: <b>0191600929</b>
Personal Physician or Clinic:		Physician's Phone: <b>0233832678</b>	
Address:		Date: <b>25/03/23</b>	

Seafarer's Signature

*WLS*

ALLERGIES:

Family History Has anyone in your family ever had:

	Yes		No	
	Yes	No	Yes	No
Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Epilepsy/Seizure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<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 checked="" type="checkbox"/>
Testicular Lumps	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Breast Lumps	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Penile Discharge	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Menstrual Problems	<input type="checkbox"/>	<input checked="" 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)

Are you presently on any medication:  Yes  No

If yes, Please list prescription and over the counter medications you take regularly:

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:

Would you say that your health is (please check one):  Excellent  Good  Fair

DECLARATION

I, MD. WALID HOSSAIN SHAKIL, C107845 Seaman's Number C107845 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.