THE AMERICAN CLUB

# AMERICAN CLUB
# MEDICAL HISTORY QUESTIONNAIRE

Hologram Sticker No.:

Dr.'s Initials

DR. M. ABUBUR RAHMAN (Medicine) M.B.B.S. P.G.T. Agrabad C/A, Chittagong Taher

| | | | | | |
|---|---|---|---|---|---|
| Name: | MUHAMMAD ALI | | | Date of Birth : | 10.10.94 |
| Address : | VILL: NORTH BANDER P.O: MOHAL KHAN BAZER P.S: KHARNAPHULI DIST: C | | | | |
| | | Seaman Certificate No.: | 050008161 | Phone : | 01643-348683 |
| Employer : | | Vessel : | T/3/526 M.V. ROYAL IMAGE | Job Title : | OILER |
| In Emergency, Notify : | Abden Ali | Relationship : | FATHER | Ph. : | 01812-607078 |
| Personal Physician or Clinic : | | | | | |
| Address : | | | | | |
| | | Physician's Phone : | 02333313678 | | |

Ali

Date : 17.09.23

ALLERGIES:

**Family History** Has anyone in your family ever had :

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Diabetes | ☐ | ☑ | Heart Disease | ☐ | ☑ | Mental Illness | ☐ | ☑ |
| High Blood Pressure | ☐ | ☑ | Cancer | ☐ | ☑ | Epilepsy/Seizure | ☐ | ☑ |

If "Yes", to any of the above, please explain:

Any other major conditions?

| MALES ONLY | Yes | No | If yes, give details : | FEMALES ONLY | Yes | No |
|---|---|---|---|---|---|---|
| Prostate Problems | ☐ | ☑ | | Pregnancy | ☐ | ☐ |
| Testicular Lumps | ☐ | ☑ | | Breast Lumps | ☐ | ☐ |
| Penile Discharge | ☐ | ☑ | | Menstrual Problems | ☐ | ☐ |

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 | ☐ | ☑ | Jaundice or Hepatitis | ☐ | ☑ |
| Heart Trouble | ☐ | ☑ | Dizziness | ☐ | ☑ |
| High Blood Pressure | ☐ | ☑ | Back Problems | ☐ | ☑ |
| Shortness of Breath | ☐ | ☑ | Slipped Disc | ☐ | ☑ |
| Chest Pain | ☐ | ☑ | Wrist Problems | ☐ | ☑ |
| Chronic Cough | ☐ | ☑ | Fractured Vertebrae | ☐ | ☑ |
| Asthma | ☐ | ☑ | Arthritis / Gout | ☐ | ☑ |
| Tuberculosis | ☐ | ☑ | Kidney Problems | ☐ | ☑ |
| Rheumatic Fever | ☐ | ☑ | Cancer / Tumor | ☐ | ☑ |
| Frequent Headaches | ☐ | ☑ | Rash or Skin Problem | ☐ | ☑ |
| Vision Problems | ☐ | ☑ | Hernia / Hydrocele | ☐ | ☑ |
| 20/20 Vision | ☐ | ☑ | Varicose Veins | ☐ | ☑ |
| Epilepsy | ☐ | ☑ | Drug Problems | ☐ | ☑ |
| Hearing Problems | ☐ | ☑ | Mental Breakdown | ☐ | ☑ |
| Psychological Impairment, Depression or Mental Illness | | | | ☐ | ☑ |
| Sexually Transmitted Disease | | | | ☐ | ☑ |

| | Yes | No | | |
|---|---|---|---|---|
| Do you or did you smoke? | ☐ | ☑ | How long? | |
| | | | Packs per day? | |
| Do you use alcoholic beverages? | ☐ | ☑ | How much/often? | |
| Do you use or take any drugs? | ☐ | ☑ | 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, MUHAMMAD ALI, Seaman's Number T/3/526, **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.