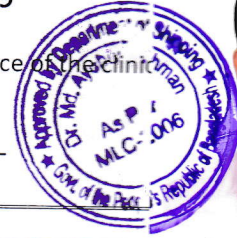




# AMERICAN CLUB MEDICAL HISTORY QUESTIONNAIRE—2019

**IMPORTANT:** This medical history form must be completed in the presence of the clinician/physician.

American Club Hologram Sticker No. (from previous page): \_\_\_\_\_  
Doctor's Initials: \_\_\_\_\_



Name: RABBANY Last Name      SYED First Name      GOLAM Middle Name

Home Address: SULTANSHABILY, MOSHAJAN, MOBIKANDI SAOAR, HARIKANJ.

Date of Birth (dd/mm/yyyy): 27-10-1998      Phone No. \_\_\_\_\_      Seaman's Certificate No.: T/31866      Employer: VANGUARD MARITIME

In case of emergency, notify: \_\_\_\_\_      Relationship: \_\_\_\_\_      Address: \_\_\_\_\_      Phone No.: \_\_\_\_\_

*Syed Golam Rabbany*  
Seafarer's Signature

Personal Physician or Clinic: \_\_\_\_\_      Physician's Phone No.: 02-333313678

Address: \_\_\_\_\_

Family History					
	YES	NO		YES	NO
Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart Disease	<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 medical or physical conditions? \_\_\_\_\_

MALE ONLY	YES	NO	FEMALE ONLY	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 Issues	<input type="checkbox"/>	<input type="checkbox"/>

If "YES" to any of the above, please explain: \_\_\_\_\_

Are you currently under a doctor's care?      YES       NO

If "YES", for what problem(s)? \_\_\_\_\_

Physician's name and address (if different from the one noted above) \_\_\_\_\_

Have you had surgeries or have been hospitalized?      YES       NO

If "YES", provide the date(s) and give details below: \_\_\_\_\_

Date of last Tetanus vaccination: \_\_\_\_\_ (dd/mm/yyyy)

List other vaccinations/dates: \_\_\_\_\_ (dd/mm/yyyy)

Date of last dental cleaning: \_\_\_\_\_ (dd/mm/yyyy)

Date of any recent dental work: \_\_\_\_\_ (dd/mm/yyyy)

Overall, would you say that your health is (please check only one):

Excellent       Good       Fair

Have you 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 Disk	<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 Problems	<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/Seizure	<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"/>			

**Allergies**      YES       NO

Do you have any allergies? \_\_\_\_\_

If you have allergies, please describe: \_\_\_\_\_

	YES	NO	
Do you smoke?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", how long? If "YES", how many packs per day?
Do you drink alcohol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", how much and how often?
Do you use or take any drugs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	If "YES", name the drugs and how often used?

Are you presently on any medication(s)?      YES       NO

If "YES", please list prescription and over the counter medications you take regularly: \_\_\_\_\_

**DECLARATION**  
I, SYED GOLAM RABBANY, Seaman's Number T/31866, 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.

**Fit For Duty on Board Ship**