# NAME OF CLINIC

DOH ACCREDITATION NUMBER
Clinic Address
Clinic Contact Information
Email Address

A.O. No. 2013-0006

PASSPORT SIZE PHOTO

## MEDICAL EXAMINATION REPORT FOR SEAFARERS

**Approved and authorized by the Department Of Health (DOH) and the Maritime Industry Authority (MARINA) of the Republic of the Philippines Issued in compliance with STCW Convention, 1978, as amended Section A-I/9 Paragraph 7 and the Maritime Labour Convention, 2006**

| | | | |
|---|---|---|---|
| SURNAME/LAST NAME: Dela Cruz | GIVEN NAME: Juan | | MIDDLE NAME: Carlos |
| AGE: 23 | DATE OF BIRTH: 1 DAY 1 MONTH 2000 YEAR | PLACE OF BIRTH: Pasay CITY Philippines COUNTRY | NATIONALITY: Filipino |
| GENDER: MALE ☑ FEMALE ☐ | CIVIL STATUS: SINGLE ☑ MARRIED ☐ | | RELIGION: Christian |
| ADDRESS: Unit 141 Megabuilding, Taft Avenue, Metro Manila | | | |
| PASSPORT NUMBER: B1047832A | SEAMAN'S BOOK NUMBER: 825481 | | |
| POSITION APPLIED FOR: DECK ☐ ENGINE ☑ CATERING ☐ OTHERS ☐ (Specify) | | | |
| NAME OF COMPANY: Magic Company XYZ | | | |

**I. MEDICAL HISTORY - Has applicant suffered from, been diagnosed, sought advice or treatment from a medical doctor on the following conditions:**
**Place a check mark (✓) in the appropriate box ☐.**

| | | | |
|---|---|---|---|
| Head or Neck Injury YES ☐ NO ☐ | Other Lung Disorders YES ☐ NO ☐ | Gynaecological Disorders YES ☐ NO ☐ | |
| Frequent Headaches YES ☐ NO ☐ | High Blood Pressure YES ☐ NO ☐ | Last Menstrual Period, specify date ____ | |
| Frequent Dizziness YES ☐ NO ☐ | Heart Disease/ Vascular/ Chest Pain YES ☐ NO ☐ | Kidney or Bladder Disorder YES ☐ NO ☐ | |
| Fainting Spells, Fits, Seizures or Other Neurological Disorders YES ☐ NO ☐ | Rheumatic Fever YES ☐ NO ☐ | Back Injury/Joint Pain/ Arthritis YES ☐ NO ☐ | |
| Insomnia or Sleep Disorders YES ☐ NO ☐ | Diabetes Mellitues YES ☐ NO ☐ | Genetic, Hereditary or Familial Disorders YES ☐ NO ☐ | |
| Depression, other Mental Disorders YES ☐ NO ☐ | Other Endocrine Disorders (e.g. Goiter) YES ☐ NO ☐ | Sexually Transmitted Diseases YES ☐ NO ☐ | |
| Eye Problems/ Error of Refraction YES ☐ NO ☐ | Cancer or Tumor YES ☐ NO ☐ | Tropical Diseases (e g. Malaria, Typhoid Fever, specify date) YES ☐ NO ☐ | |
| Deafness, Other Ear Disorders YES ☐ NO ☐ | Blood Disorders YES ☐ NO ☐ | Schistosomiasis (Specify date: ____) YES ☐ NO ☐ | |
| Nose or Throat Disorders YES ☐ NO ☐ | Stomach Pain, Gastritis or Ulcer YES ☐ NO ☐ | Asthma YES ☐ NO ☐ | |
| Tuberculosis YES ☐ NO ☐ | Other Abdominal Disorders YES ☐ NO ☐ | Allergies (Specify. ____) YES ☐ NO ☐ | |

Previous Hospitalization(s)/ Operation(s).

**Place a check mark (✓) in the appropriate box ☐.**

| | | YES | NO |
|---|---|---|---|
| 1. | Have you ever been signed off as sick or repatriated from a ship? | ☐ | ☐ |
| 2. | Have you ever been hospitalized? | ☐ | ☐ |
| 3 | Have you ever been declared unfit for sea duty? | ☐ | ☐ |
| 4 | Has your medical certificate ever been restricted or revoked? | ☐ | ☐ |
| 5. | Are you aware that you have any medical problem, disease or illness? | ☐ | ☐ |
| 6. | Do you feel healthy and fit to perform the duties of your designated position/occupation? | ☐ | ☐ |
| 7. | Are you allergic to any medication? Comments ____ | ☐ | ☐ |
| 8. | Are you taking any non-prescription or prescription medication? If yes, please list the medication(s) taken/being taken, and the purpose(s) and dosage(s) | ☐ | ☐ |

**II. MEDICAL EXAMINATION**
**Enter the data called for. Place a check mark (✓) in the appropriate box ☐.**

| | | | | | | |
|---|---|---|---|---|---|---|
| HEIGHT (cm). | WEIGHT (kg): | BLOOD PRESSURE: Systolic: ____ (mm Hg) Diastolic: ____ (mm Hg) | PULSE RATE ____/min RHYTHM: ____ | RESPIRATION: ____/min | | BMI. |
| VISUAL ACUITY | FAR VISION | NEAR VISION | ISHIHARA COLOR VISION | EAR | Hearing by Audiometry | CLARITY OF SPEECH |
| Uncorrected | OD 20/ OS 20/ | ODJ OSJ | Adequate ☐ | Right | ☐ Adequate ☐ Inadequate | Adequate ☐ |
| Corrected | OD 20/ OS 20/ | ODJ OSJ | Defective ☐ | Left | ☐ Adequate ☐ Inadequate | Defective ☐ |