Medical History

Personal Details	
Full Name:	
Date of Birth (DD-MMM-YYYY):	
Sex:	

Personal Declaration							
Please answer if any of the following are applicable:							
		Yes	No			Yes	No
1	Eye/vision problems			2	Sleep problems		
2	High blood pressure			4	Smoker		
3	Heart/vascular disease			6	Operation(s)/surgery(s)		
5	Heart surgery			8	Epilepsy/seizures		
7	Varicose veins			10	Dizziness/fainting		
9	Asthma/bronchitis			12	Loss of consciousness		
11	Blood disorder			14	Psychiatric problems		
13	Diabetes			16	Depression		

15	Thyroid problems			18	Attempted suicide		
17	Digestive disorder(s)			20	Loss of memory		
19	Kidney disorders(s)			22	Balance problems		
21	Derminterlogical disorder(s)			24	Headaches/migraines		
23	Allergies			26	Ear/nose/throat problems		
25	Infectious/contagious disease			28	Restricted mobility		
27	Hernia			30	Back problems		
29	Genital disorders			32	Amputation		
31	Pregnancy (current)			34	Fractures/dislocations		

If you answered 'Yes' to any of the above, please provide details:

Additional Questions		
Have you ever been signed off as sick or repatriated from a vessel?	Yes	No
Have you ever been hospitalized?		
Have you ever been declared unfit for duty?		
Has your medical certificate ever been restricted or revoked?		
Are you aware of any current medical problems?		
Do you feel healthy and fit to perform the duties of your designated position?		
Are you allergic to any medications?		
Are you currently taking any prescription medications?		
If you answered 'Yes' to any of the above, please provide details:		

I, , do hereby affirm that the above information is a true statement to the best of my knowledge.

Signature of Seafarer: Date:

DAYBOARD MARITIME