MEDICAL HISTORY

Date: _____

(Please Print)

Name: _____
Address: _____
_____
Telephone No.: _____
Social Security no.: _____
Next of Kin: _____
Address: _____
_____
Telephone No.: _____

Date of Birth: _____
Place of Birth: _____
Race/Nationality: _____ Native Language: _____
Educational Level: _____
Years Maritime Service: _____
Maritime Rating: _____ Marital Status: _____
Citizenship: ☐ Native ☐ Naturalized ☐ Alien
Family Doctor: _____
Address: _____
Telephone No.: _____

Family Illnesses

Check if there is any history in your family of:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Heart Trouble
- ☐ Tuberculosis
- ☐ Alchoholism
- ☐ Jaundice
- ☐ Easy Bleeding
- ☐ Obesity
- ☐ Gout
- ☐ Asthma
- ☐ Psychiatric Illness
- ☐ Allergy
- ☐ High Blood Fats
- ☐ Cancer of _____
- ☐ Other _____

Statement of Present Health

Your Statement of present health:
☐ excellent ☐ good
☐ fair/poor (explain)

Do you take non-prescription drugs routinely?
☐ no ☐ yes specify:

Do you take prescription drugs routinely?
☐ no ☐ yes specify:

Do you use recreational drugs?
☐ no ☐ yes specify:

Are you under the care of a physician now?
☐ no ☐ yes specify:

What is your:

Height _____
Usual Weight _____
Usual Blood Pressure _____
Usual pulse _____
Color hair _____
Color eyes _____

Vision:	R	L
With glasses	/20	/20
Without glasses	/20	/20

Past Medical History (for additional space use back page)

Have you ever been refused employment or been unable to hold a job or stay in school because of:

	Yes	No	Don't Know
1. Sensitivity to chemicals, dust, sunlight, etc	☐	☐	☐
2. Inability to perform certain motions	☐	☐	☐
3. Inability to assume certain positions	☐	☐	☐
4. Other medical reasons (if yes, give reasons.)	☐	☐	☐
5. Have you ever been treated for a nervous condition? (if yes, specify when, where, and give details)	☐	☐	☐
6. Have you ever been denied life insurance (if yes, state reason and give details)	☐	☐	☐
7. Have you had, or have you been advised to have any operations? (if yes, describe and give age at which occurred)	☐	☐	☐
8. Have you ever been a patient in any type of hospitals? [if yes, specify when, where, why and name of doctor and complete address of hospital.]	☐	☐	☐
9. Date of last physical:_____ ; Date of last hospitalization: _____; No. of days: _____			
10. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the last 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, and details).	☐	☐	☐
11. Have you ever been rejected for military service because of physical, mental, or other reasons? [if yes, give date, and reasons for rejection].	☐	☐	☐
12. Have you ever been discharged from military service because of physical, mental, or other reasons? [if yes, give date, reasons, and type of discharge: honorable, other than honorable, unfit, or unsuitable].	☐	☐	☐
13. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, what amount, when, and why?)	☐	☐	☐
14. Weight at age 18: _____			
15. Have you ever:			
Lived with anyone who had tuberculosis?	☐	☐	☐
Coughed up blood?	☐	☐	☐
Bled excessively after injury or tooth extraction?	☐	☐	☐
Attempted suicide?	☐	☐	☐
Been a sleepwalker?	☐	☐	☐
16. Do you:			
Wear glasses or contact lenses?	☐	☐	☐
Have vision in both eyes?	☐	☐	☐
Wear a hearing aid?	☐	☐	☐
Stutter or stammer habitually?	☐	☐	☐
Wear a brace, back support or truss?	☐	☐	☐

Past Medical History (Con't.)

17. Have you ever had or have you now (please check at right of each item).

	Yes	No	Don't Know		Yes	No	Don't Know		Yes	No	Don't Know
Scarlet fever	☐	☐	☐	Emphysema	☐	☐	☐	"Trick" or locked knee	☐	☐	☐
Rheumatic Fever	☐	☐	☐	Limit of joint motion	☐	☐	☐	Foot trouble	☐	☐	☐
Swollen or painful joints	☐	☐	☐	Cramps in your legs	☐	☐	☐	Neuritis	☐	☐	☐
Frequent or severe headache	☐	☐	☐	Frequent indigestion, stomach ulcer	☐	☐	☐	Paralysis (include infantile)	☐	☐	☐
Dizziness / fainting spells	☐	☐	☐	Stomach, liver or intestinal trouble	☐	☐	☐	Epilepsy or fits	☐	☐	☐
Eye trouble	☐	☐	☐	Gall bladder trouble or gallstones	☐	☐	☐	Car, train, sea or air sickness	☐	☐	☐
Ear, nose or throat trouble	☐	☐	☐	Jaundice or hepatitis	☐	☐	☐	Frequent trouble sleeping	☐	☐	☐
Hearing loss	☐	☐	☐	Adverse reaction to serum, drug,				Depression or excessive worry	☐	☐	☐
Chronic or frequent colds	☐	☐	☐	medicine or foods	☐	☐	☐	Loss of memory or amnesia	☐	☐	☐
Severe tooth/gum trouble	☐	☐	☐	Broken bones	☐	☐	☐	Nervous trouble of any sort	☐	☐	☐
Sinusitis	☐	☐	☐	Tumor, growth, cyst, cancer	☐	☐	☐	Periods of unconciousness	☐	☐	☐
Hay fever	☐	☐	☐	Rupture/hernia	☐	☐	☐	Gout	☐	☐	☐
Head injury	☐	☐	☐	Piles or rectal disease	☐	☐	☐	Hardening of arteries	☐	☐	☐
Skin diseases	☐	☐	☐	Frequent/painful urination	☐	☐	☐	Anemia/blood disorder	☐	☐	☐
Thyroid trouble	☐	☐	☐	Bet wetting since age 12	☐	☐	☐	Glaucoma	☐	☐	☐
Tuberculosis	☐	☐	☐	Kidney stones or blood in urine	☐	☐	☐	Abnormal chest X-ray	☐	☐	☐
Asthma	☐	☐	☐	Surgar or albumin in urine	☐	☐	☐	Abnormal G.I. X-ray	☐	☐	☐
Shortness of breath	☐	☐	☐	STD (Sexually transmitted Disease)--				Abnormal EKG	☐	☐	☐
Pain or pressure in chest	☐	☐	☐	syphillis, gonorrhea	☐	☐	☐	Use Tobacco	☐	☐	☐
Chronic cough	☐	☐	☐	Recent weight gain or loss	☐	☐	☐	Use alchohol	☐	☐	☐
Palpitation/pounding heart	☐	☐	☐	Arthritis, rheumatism, or bursitis	☐	☐	☐	Painful or "trick" shoulder or			
Heart trouble	☐	☐	☐	Bone, joint or other deformity	☐	☐	☐	elbow	☐	☐	☐
High or low blood pressure	☐	☐	☐	Lameness	☐	☐	☐	Recurrent back pain	☐	☐	☐
Bronchitis	☐	☐	☐	Loss of finger or toe	☐	☐	☐	FEMALES ONLY: Have you ever			
				Kidney/bladder trouble	☐	☐	☐	Been treated for a female disorder	☐	☐	☐
				Herpes	☐	☐	☐	Had a change in menstrual pattern	☐	☐	☐

Immunizations

Have you had any of the following immunizations? Date/Mo/Yr (example: 30 Nov 82)

	Yes	No	Don't Know	Date		Yes	No	Don't Know	Date		Yes	No	Don't Know	Date
Tetanus	☐	☐	☐	_____	BCG (TB)	☐	☐	☐	_____	Gamma globulin	☐	☐	☐	_____
Smallpox	☐	☐	☐	_____	Cholera	☐	☐	☐	_____	Diptheria	☐	☐	☐	_____
Yellow Fever	☐	☐	☐	_____	Typhoid	☐	☐	☐	_____	Malaria	☐	☐	☐	_____
Plague	☐	☐	☐	_____	Typhus	☐	☐	☐	_____	Other	☐	☐	☐	_____

Medical Release

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowlege. I hereby authorize facilities holding my medical records to release a transcript to the physicians at Medical Advisory System Inc. (MAS) for the purpose of providing medical advice for my treatment for medical problems which could occur aboard a unit of a company subscribing to the services of MAS. I also authorize MAS to maintain, periodically update and release this information to shoreside medical facilities for continuation of medical care.

_____

Signature (Seafarer, Employee, etc.) **Date**

This record is being provided by (Name of Subscribing Company) _____

Additional Information