



PRE-SEA AND PERIODIC MEDICAL FITNESS EXAMINATIONS FORM FOR SEAFARERS
(In accordance with ILO /WHO D.2/ 1997 & STCW Reg I/9 and MLC Reg 1.2)

Family Name	
Given Names	
Date of birth (day/month/year)	
Sex:	Male Female Please encircle
Home address	
Seaman Service Book No.:	
Nationality:	
Type of ship (container, tanker, Bulk carrier, General cargo)	
Trade area (e.g., coastal, tropical, worldwide)	

A. EXAMINEE'S PERSONAL DECLARATION *(Assistance should be offered by medical staff)*

Have you ever had any of the following conditions?

Condition	Yes	No	Condition	Yes	No
1. Eye/vision problem	<input type="checkbox"/>	<input type="checkbox"/>	18. Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>
2. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	19. Do you smoke ?	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart/vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	20. Operation/surgery	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	21. Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>
5. Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	22. Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>
6. Asthma/bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	23. Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
7. Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	24. Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>
8. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	25. Depression	<input type="checkbox"/>	<input type="checkbox"/>
9. Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	26. Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>
10. Digestive disorder	<input type="checkbox"/>	<input type="checkbox"/>	27. Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
11. Kidney problem	<input type="checkbox"/>	<input type="checkbox"/>	28. Balance problem	<input type="checkbox"/>	<input type="checkbox"/>
12. Skin problem	<input type="checkbox"/>	<input type="checkbox"/>	29. Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
13. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	30. Ear/nose/throat problems	<input type="checkbox"/>	<input type="checkbox"/>
14. Infectious/contagious diseases	<input type="checkbox"/>	<input type="checkbox"/>	31. Restricted mobility	<input type="checkbox"/>	<input type="checkbox"/>
15. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	32. Back problems	<input type="checkbox"/>	<input type="checkbox"/>
16. Genital disorders	<input type="checkbox"/>	<input type="checkbox"/>	33. Amputation	<input type="checkbox"/>	<input type="checkbox"/>
17. Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	34. Fractures/dislocations	<input type="checkbox"/>	<input type="checkbox"/>

If any of the above questions were answered "yes", please give details.

Additional questions

		Yes	No
35.	Have you ever been signed off as sick or repatriated from a ship?	<input type="checkbox"/>	<input type="checkbox"/>
36.	Have you ever been hospitalised?	<input type="checkbox"/>	<input type="checkbox"/>
37.	Have you ever been declared unfit for sea duty?	<input type="checkbox"/>	<input type="checkbox"/>
38.	Has your medical certificate ever been restricted or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
39.	Are you aware that you have any medical problems, diseases or illnesses	<input type="checkbox"/>	<input type="checkbox"/>
40.	Do you feel healthy and fit to perform the duties of your designated position/occupation?	<input type="checkbox"/>	<input type="checkbox"/>
41.	Are you allergic to any medications?	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
42.	Are you taking any non-prescription or prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list the medications taken and the purpose(s) and dosage(s)			

I hereby certify that the personal declaration above is a true statement to the best of my knowledge.

Signature of examinee: _____ Date (day/month/year) ____/____/____

Witnessed by: (Signature) _____ Name: (typed or printed) _____

I hereby authorize the release of all my previous medical records from any health professionals, health institutions and public authorities to Dr. _____ (the approved medical examiner).

Signature of examinee: _____ Date (day/month/year) ____/____/____

Witnessed by: (Signature) _____ Name: (typed or printed) _____

B. MEDICAL EXAMINATION

Pre-sea

Periodic

Other

Sight as per section A-I/9:

	Visual acuity						Visual fields	
	Unaided			Aided			Normal	Defective
	Right eye	Left eye	Bino-cular	Right eye	Left eye	Bino-cular		
Distant								
Near								

Colour vision as per section A-I/9: Normal Doubtful Defective

Date of last colour vision test: Date (day/month/year) ____/____/____

Hearing as per section A-I/9:

Pure tone and audio metry (threshold values in dB)

Speech and whisper test (metres)

	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz		Normal	Whisper
Right ear							Right ear		
Left ear							Left ear		

Height	cm	Weight	kg
Pulse rate	(/ minute)	Rhythm	
Blood pressure	mm Hg	Diastolic	mm Hg
Systolic			
Urinalysis		Protein	
Glucose			

	Normal	Abnormal		Normal	Abnormal
Head	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Sinuses, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	Vascular (inc. pedal pulses)	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/teeth	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen and viscera	<input type="checkbox"/>	<input type="checkbox"/>
Ears (general)	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Tympanic membrane	<input type="checkbox"/>	<input type="checkbox"/>	Anus (not rectal exam)	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	G-U system	<input type="checkbox"/>	<input type="checkbox"/>
Ophthalmoscopy	<input type="checkbox"/>	<input type="checkbox"/>	Upper and lower extremitie	<input type="checkbox"/>	<input type="checkbox"/>
Pupils	<input type="checkbox"/>	<input type="checkbox"/>	Spine (C/S, T/S and L/S)	<input type="checkbox"/>	<input type="checkbox"/>
Eye movement	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic (full brief)	<input type="checkbox"/>	<input type="checkbox"/>
Lungs and chest	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Breast examination	<input type="checkbox"/>	<input type="checkbox"/>	General appearance	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>

Chest X-ray	<input type="checkbox"/> Not performed	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
	Performed on (day/month/year): ____/____/____		
Results:			

Other diagnostic test(s) and result(s):

Test	Result					
Haemoglobin "Hb" *1	g/dl					
Sedimentation rate "SR" *1	mm/hr					
Hepatitis B *3	HB (ab)	<input type="checkbox"/> +ve	<input type="checkbox"/> -ve	HB (ag)	<input type="checkbox"/> +ve	<input type="checkbox"/> -ve
Bacteriological stool test*4	<input type="checkbox"/> not performed		<input type="checkbox"/> negative		<input type="checkbox"/> positive	
Parasitological stool test*5	<input type="checkbox"/> not performed		<input type="checkbox"/> negative		<input type="checkbox"/> positive	
ECG *1						
HIV *2 (+ve or -ve)						
Medical examiner's comments:						

*1 compulsory

*2 not compulsory

*3 required by the Company for all crew from endemic areas

*4 required by the Company for all food handlers

*5 required by the Company for all food handlers from tropical climates

Status of vaccination records:	<input type="checkbox"/> satisfactory	<input type="checkbox"/> to be renewed	Details
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Assessment of fitness for service at sea:

On the basis of the examinee's personal declaration, my clinical examination and the diagnostic test results recorded above, I declare the examinee medically:

Fit for look-out duty Not fit for look-out duty

	Deck service	Engine service	Catering service	Other services
Fit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unfit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Without restrictions With restrictions

Is the Seafarer free from any medical conditions likely to be aggravated by service at sea or to render the seafarer unfit for such service or to endanger the health of other persons on board?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Describe restrictions (e.g., specific position, type of ship, trade area):

Action taken by medical examiner (e.g., referral):

Place of examination: _____ Date (day/month/year) ____/____/____

Certificate is valid 2 years from its issuance date or until Date (day/month/year) ____ / ____ / ____

Official stamp (also print name of medical examiner):

Signature of medical examiner: _____

Authorized by: _____

(Sign and stamp of Government Surveyor on behalf of competent authority)