SEAFARER'S FAMILY HISTORY AND MEDICAL DECLARATION FORM

Position: _____
Name of Last Company: _____ Date of last Signed Off: _____
Name of Previous PEME Clinic: _____ Date of last FTW: _____

A. PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____
Home Address: _____ Email: _____
Mobile Number: _____

B. MEDICAL HISTORY *(If applicable)*

Any history of medical reported while on board or medical repatriation? _____
Medical Complaint or findings: _____
When it happened: _____
Name of Company: _____
Was the medical case was file closed or still pending:_____

C. Have you ever been diagnosed with or suffered from any of the following conditions? (Please check YES or NO and provide required details)

Conditions	Yes	No	Prescribed Medication
Hypertension (High Blood Pressure)			
Diabetes **Type: _____**			
Heart Disease			
Tuberculosis			
Asthma or Other Respiratory Diseases			
Epilepsy or Seizures			
Kidney Disease			
Liver Disease (Hepatitis, Cirrhosis, etc.)			
Cancer **Type:_____**			
Neurological Disorders (Stroke, Parkinson's)			
Anxiety Disorders (Depression, Anxiety)			
Gastrointestinal Disorders			
Appendicitis			
Vision or Eye Disorders			
Hearing Impairment(loss)			
Blood Disorders			
Thyroid Disorders			
Arthritis			
Gout			
Prostate Enlargement			
Others: **Specify**: _____			

Conditions	Yes	No	Specify the Condition/ Medication
Have you undergone any surgery in the past 10 years? Specify:_____			
Are you currently taking any prescription or over-the-counter medications?			
Do you have any allergies (food, medication)?			
Have you been hospitalized in the last 5 years?			
Do you have any physical disabilities, impairments, or chronic pain?			
Do you have any history of substance or alcohol dependency?			
Have you experienced any recent weight loss or gain (over 10 kg in 6 months)?			
Do you have any sleeping disorders (Insomnia, Sleep Apnea)?			

D. FAMILY MEDICAL HISTORY (Please indicate if any immediate family members have had the following conditions)

Conditions	Yes	No	Relation to the Family Member
Hypertension (High Blood Pressure)			
Diabetes **Type: _____**			
Heart Disease			
Cancer **Specify:_____**			
Asthma or Other Respiratory Diseases			
Kidney Disease			
Liver Disease (Hepatitis, Cirrhosis, etc.)			
Others: **Specify: _____**			

E. Medication

DECLARATION AND CONSENT I hereby declare that the information provided above is true and correct to the best of my knowledge. I understand that non-disclosure or false declaration may result in legal consequences and employment.

Name & Signature of Crew:_____

Date: _____