



FORMAT FOR RECORDING MEDICAL EXAMINATIONS OF SEAFARERS

Name (last, first, middle): _____

Date of birth (day/month/year): ____/____/____ Sex: Male Female

Home address: _____

Passport No./discharge book No: _____

Department: (deck/engine/radio/food handling/other): _____

Routine and emergency duties: _____

Type of ship (container, tanker, passenger, fishing): _____

Trade area (e.g., coastal, tropical, worldwide): _____

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.	Problemas de los ojos / visión	<input type="checkbox"/>	<input type="checkbox"/>	19.	Do you smoke, use alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
2.	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	20.	Operation/surgery	<input type="checkbox"/>	<input type="checkbox"/>
3.	Heart/vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	21.	Epilepsy/ seizures	<input type="checkbox"/>	<input type="checkbox"/>
4.	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	22.	Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>
5.	Varicose veins/piles	<input type="checkbox"/>	<input type="checkbox"/>	23.	Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
6.	Asthma/bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	24.	Problemas psiquiátricos	<input type="checkbox"/>	<input type="checkbox"/>
7.	Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	25.	Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
8.	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	26.	Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>
9.	Thyroid problema	<input type="checkbox"/>	<input type="checkbox"/>	27.	Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
10.	Digestive disorder	<input type="checkbox"/>	<input type="checkbox"/>	28.	Balance problem	<input type="checkbox"/>	<input type="checkbox"/>
11.	Kidney problema	<input type="checkbox"/>	<input type="checkbox"/>	29.	Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
12.	Skin problema	<input type="checkbox"/>	<input type="checkbox"/>	30.	Ear (hearing/ tinnitus) nose/throat problems	<input type="checkbox"/>	<input type="checkbox"/>
13.	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	31.	Restricted mobility	<input type="checkbox"/>	<input type="checkbox"/>
14.	Infectious/contagious diseases	<input type="checkbox"/>	<input type="checkbox"/>	32.	Back or joint problem	<input type="checkbox"/>	<input type="checkbox"/>
15.	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	33.	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
16.	Genital disorders	<input type="checkbox"/>	<input type="checkbox"/>	34.	Fractures/dislocation	<input type="checkbox"/>	<input type="checkbox"/>
17.	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
18.	Sleep problem	<input type="checkbox"/>	<input type="checkbox"/>			<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 hospitalized?	<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 illness?	<input type="checkbox"/>	<input type="checkbox"/>
40.	¿ Do you feel healthy and fit to perform the duties of your designed position/occupation?	<input type="checkbox"/>	<input type="checkbox"/>
41.	¿ Are you allergic to any medications?	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

		SI	NO
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: _____

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 practitioner).

Signature of examinee: _____

Date (day/month/year): ____ / ____ / ____

Witnessed by: (Signature): _____

Name: (Typed or printed): _____

Date and contact details for previous medical examination (if known): _____

MEDICAL EXAMINATION

Sight

Use of glasses or contact lenses: Yes/No (if yes, specify which type and for what purpose)

	Visual acuity						Visual fields			
	Unaided			Aided			Normal	Defective		
	Right eye	Left eye	Binocular	Right eye	Left eye	Binocular				
Distant							Right eye			
							Left eye			

Olor vision	<input type="checkbox"/> Not tested	<input type="checkbox"/> Normal	<input type="checkbox"/> Doubtful	<input type="checkbox"/> Defective
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Hearing

	Pure tone and audio metry (threshold values in dB)						Speech and whisper test (metres)			
							Normal	Whisper		
	500 Hz	1,000 Hz	2,000 Hz	3,000 Hz						
Right eye							Right eye			
Left eye							Left eye			

Clinical data

Height: _____ (cm)

Weight: _____ (kg)

Pulse rate: _____ (/minute)

Rhythm: _____

Blood pressure:

Systolic : _____ (mmHg)

Diastolic : _____ (mmHg)

Urinalysis: Glucose: _____ Protein: _____ Blood: _____

	Normal	Abnormal		Normal	Abnormal
Head	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>
Sinuses, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	Varicose venis	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/teeth	<input type="checkbox"/>	<input type="checkbox"/>	Vascular (inc. Pedal pulses)	<input type="checkbox"/>	<input type="checkbox"/>
Ears (general)	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen and viscera	<input type="checkbox"/>	<input type="checkbox"/>
Tympanic membrane	<input type="checkbox"/>	<input type="checkbox"/>	Hernias	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Anus (not rectal exam.)	<input type="checkbox"/>	<input type="checkbox"/>
Ophthalmoscopy	<input type="checkbox"/>	<input type="checkbox"/>	G-U system	<input type="checkbox"/>	<input type="checkbox"/>
Pupils	<input type="checkbox"/>	<input type="checkbox"/>	Upper and lower extremities	<input type="checkbox"/>	<input type="checkbox"/>
Eye movement	<input type="checkbox"/>	<input type="checkbox"/>	Spine (C/S, T/S and L/S)	<input type="checkbox"/>	<input type="checkbox"/>
Lungs and chest	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic (full brief)	<input type="checkbox"/>	<input type="checkbox"/>
Breast examination	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	General appearance	<input type="checkbox"/>	<input type="checkbox"/>
Chest X-ray	<input type="checkbox"/> Not performed		<input type="checkbox"/> Performed (day /month /year) _____ / _____ / _____		

Results: _____

Other diagnostic tests and results:

Test: _____ Result: _____

Medical practitioner's comments and assessment of fitness, with reasons for any limitations:

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 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 Visual aid required Si No

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

Medical certificate's date of expiration (day/month/year): ____/____/____.

Date of medical certificate issued (day/month/year): ____/____/____.

Number of medical certificate: _____

Name of medical practitioner (typed or printed): _____

License number of medical practitioner: _____

Address of medical practitioner: _____

Authorized by: Panama Maritime Authority

Signature of medical practitioner: _____

Seal:

