FORMAT FOR RECORDING MEDICAL EXAMINATIOS

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	☐	☐	19.	Do you smoke,use alcohol odrugs?	☐	☐
2.	High blood pressure	☐	☐	20.	Operation/surgery	☐	☐
3.	Heart/vascular disease	☐	☐	21.	Epilepsy/ seizures	☐	☐
4.	Heart surgery	☐	☐	22.	Dizziness/fainting	☐	☐
5.	Varicose veins/piles	☐	☐	23.	Loss of consciousness	☐	☐
6.	Asthma/bronchitis	☐	☐	24.	Problemas psiquiátricos	☐	☐
7.	Blood disorder	☐	☐	25.	Loss of consciousness	☐	☐
8.	Diabetes	☐	☐	26.	Attempted suicide	☐	☐
9.	Thyroid problema	☐	☐	27.	Loss of memory	☐	☐
10.	Digestive disorder	☐	☐	28.	Balance problem	☐	☐
11.	Kidney problema	☐	☐	29.	Severe headaches	☐	☐
12.	Skin problema	☐	☐	30.	Ear (hearing/ tinnitus) nose/throat problems	☐	☐
13.	Allergies	☐	☐	31.	Restricted mobility	☐	☐
14.	Infectious/contagius diseases	☐	☐	32.	Back or joint problem	☐	☐
15.	Hernia	☐	☐	33.	Amputation	☐	☐
16.	Genital disorders	☐	☐	34.	Fractures/dislocation	☐	☐
17.	Pregnancy	☐	☐			☐	☐
18.	Sleep problem	☐	☐			☐	☐

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?	☐	☐
36.	¿ Have you ever been hospitalized?	☐	☐
37.	¿ Have you ever been declared unfit for sea duty?	☐	☐
38.	¿ Has your medical certificate ever been restricted or revoked?	☐	☐
39.	¿ Are you aware that you have any medical problems, diseases or illness?	☐	☐
40.	¿ Do you feel healthy and fit to perform the duties of your designed position/occupation?	☐	☐
41.	¿ Are you allergic to any medications?	☐	☐

Comments:

		SI	NO
42.	¿ Are you taking any non-prescription or prescription medications?	☐	☐

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					
	Unaides			Aided		
	Right eye	Left eye	Binocular	Right eye	Left eye	Binocular
Distant						

	Visual fields	
	Normal	Defective
Right eye		
Left eye		

Olor vision	☐ Not tested	☐ Normal	☐ Doubtful	☐ Defective

Hearing

	Pure tone and audio metry (threshold values in dB)					
	500 Hz	1,000 Hz	2,000 Hz	3,000 Hz		
Right eye						
Left eye						

	Speech and whisper test (metres)	
	Normal	Whisper
Right eye		
Left eye		

Clinical data

Height: _____ (cm) Weight: _____ (kg)

Pulse rate: _____ (/minute) Rhythm: _____

Blood pressure: Systolic : _____(mmHg) Diastolic : _____(mmHg)

Urinalysis: Glucose: _____ Protein: _____ Blood: _____

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	Normal	Abnormal		Normal	Abnormal
Head	☐	☐	Skin	☐	☐
Sinuses, nose, throuat	☐	☐	Varicose venis	☐	☐
Mouth/teeth	☐	☐	Vascular (inc. Pedal pulses)	☐	☐
Ears (general)	☐	☐	Abdomen and viscera	☐	☐
Tympanic membrane	☐	☐	Hernias	☐	☐
Eyes	☐	☐	Anus (not rectal exam.)	☐	☐
Ofthalmoscopy	☐	☐	G-U system	☐	☐
Pupils	☐	☐	Upper and lower extremities	☐	☐
Eye movement	☐	☐	Spine (C/S, T/S and L/S)	☐	☐
Lungs and chest	☐	☐	Neurologic (full brief)	☐	☐
Breast examination	☐	☐	Psychiatric	☐	☐
Heart	☐	☐	General appearance	☐	☐
Chest X-ray	☐ Not performed		☐ 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	☐	☐	☐	☐
Unfit	☐	☐	☐	☐

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: