

Medical Fitness Certificate for Service on Swiss Sea-going Vessels Medical Questionnaire

Last name, First name: Date of birth:

Employer: Occupation:

Ship type (e.g. Container, Tanker, Passenger):

Area of deployment (e.g. coast, tropics, world-wide):

Last sea-fit medical examination: By whom?

Have you ever been designated as unfit to work on board a ship? no yes

If yes, when? examining physician: Grounds:

Have you ever received a medical certificate with limitations to your fitness for the seas? no yes

If yes, when? examining physician: Grounds:

Did you receive any vaccinations since your least examination for sea-fitness? no yes

If yes, please provide the details (vaccine, etc.):

!!! NB: Please do not forget to bring your vaccination certificate with you to the examination. Many Thanks !!!

Family history

Please provide, if a close member of your family (grandparents, parents or siblings) suffers or has suffered from one of the following illnesses:

High blood pressure	<input type="checkbox"/> no	<input type="checkbox"/> yes, who?
Diabetes mellitus	<input type="checkbox"/> no	<input type="checkbox"/> yes, who?
High blood lipid level	<input type="checkbox"/> no	<input type="checkbox"/> yes, who?
Heart attack	<input type="checkbox"/> no	<input type="checkbox"/> yes, who?
Stroke	<input type="checkbox"/> no	<input type="checkbox"/> yes, who?
Epilepsy	<input type="checkbox"/> no	<input type="checkbox"/> yes, who?
Others	<input type="checkbox"/> no	<input type="checkbox"/> yes, what and who?

Current health situation

Do you have any health problems currently? no yes

If yes, what are they?

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Are you at present being treated by a physician, psychotherapist, etc.? no yes

If yes, for what reasons?

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Do you glasses or contact lenses? no yes

Women: Are you pregnant? no yes

Do you practice sports? no yes: What?

Do you smoke? no yes If yes, since when? how much?

no-stopped If applicable: for how many years and how much have you smoked?

Do you drink alcohol? no yes If yes, kind, quantity, and frequency

Do you take drugs? no yes If yes, kind, quantity, and frequency

Please indicate all of the medications you are currently taking (including contraceptive pill):

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Personal medical history

Please indicate **if** and, if so, **when** you had any . . .

- . . . **serious illnesses** (e.g., stroke, cancer, for instance),
- . . . **operations** (e.g., tonsils, appendix, hernia, slipped discs, eyes, for instance), or
- . . . **accidents / injuries** (e.g., broken bones, torn ligaments, for instance).

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Systemic history

Are you suffering or have you suffered from the following illnesses?

If yes, please underline if applicable.

Epilepsy, dizziness, fainting, memory disturbances, chronic headaches, migraines, paralysis, trouble keeping balance, etc.	<input type="checkbox"/> no <input type="checkbox"/> yes
Heart complaints, heart defects, heart attacks, dysrhythmia, low or high blood pressure, collapse, vascular disease, vein problems, etc.	<input type="checkbox"/> no <input type="checkbox"/> yes
Bronchial asthma, chronic bronchitis, lung inflammation or pleurisy, lung tuberculosis, etc. etc.	<input type="checkbox"/> no <input type="checkbox"/> yes
Stomach-intestinal disturbances, (e.g., inflammations/ulcers, Morbus Crohn), gall stones, liver illnesses, pancreatitis, haemorrhoids, perianal fistula, etc.	<input type="checkbox"/> no <input type="checkbox"/> yes
Metabolic disorders (e.g., diabetes mellitus, high blood lipid level, gout, thyroid function disorders, etc.)	<input type="checkbox"/> no <input type="checkbox"/> yes
Mental disorders, acrophobia, claustrophobia, depression, suicide attempts, addictions, withdrawal treatments from alcohol, drugs, or medicine abuse	<input type="checkbox"/> no <input type="checkbox"/> yes
Sleeping disorders, snoring, nocturnal apnoea	<input type="checkbox"/> no <input type="checkbox"/> yes
Ear problems (e.g., hearing disorders, tinnitus, etc.), eye problems (cataract, glaucoma, etc.)	<input type="checkbox"/> no <input type="checkbox"/> yes
Blood diseases (e.g., anaemia, etc.), blood coagulation abnormalities, lymph node swelling	<input type="checkbox"/> no <input type="checkbox"/> yes
Spine problems (e.g., discopathy, lumbago, etc.)	<input type="checkbox"/> no <input type="checkbox"/> yes
Bone, joint (e.g., arthrosis, rheumatism, etc.) or muscular illnesses	<input type="checkbox"/> no <input type="checkbox"/> yes
Kidney illnesses (e.g., cysts, inflammations, stones, etc.)	<input type="checkbox"/> no <input type="checkbox"/> yes
Allergies (e.g., to pollen, animal fur, insects, foodstuffs, medicines, etc.) or skin illnesses (e.g., eczema, psoriasis, etc.)	<input type="checkbox"/> no <input type="checkbox"/> yes
Infectious intestinal diseases (e.g., salmonella, shigella, amoebas, giardia lamblia), urinary tract or sexual diseases	<input type="checkbox"/> no <input type="checkbox"/> yes

Were you declared unfit for military service?

no yes

If yes, why?

I herewith declare that I have accurately filled in the above information and have neither omitted important information, nor provided false data.

At the same time, I empower the physicians treating me to provide information and/or transmit my medical files to the examining agency.

Place, date:

Signature: