



Questionnaire regarding the Medical Fitness Examination for Seafarers

Please fill in this questionnaire thoroughly before your examination.

Last name:	First name:	Date of birth:
Address:	Telephone-Number (mobile and/or landline):	E-mail:
Nationality:	Birthplace and country:	
Shipping company:	Last Grade/Region of trade:	
Are you currently unfit for work? No <input type="checkbox"/> Yes <input type="checkbox"/> since when?	Initial check-up <input type="checkbox"/> Follow-up <input type="checkbox"/> Date of last medical fitness examination for seafarers (MM/YYYY): Physician's name and place: I have brought <input type="checkbox"/> lost <input type="checkbox"/> not brought <input type="checkbox"/> my German Medical Certificate for Service at Sea.	
Does your employer pay accident insurance contribution for you to BG Verkehr / Are you employed under German flag? No <input type="checkbox"/> yes <input type="checkbox"/> Please include proof of insurance. <small>(Download www.deutsche-flagge.de)</small>		

Have you ever been declared medically unfit? (medical fitness examination for seafarers, medical fitness examination for military service, etc.) No <input type="checkbox"/> Yes <input type="checkbox"/>	Have you been certified to be unfit for work within the last two years or have you been transferred from the ship to a position at land due to illness? No <input type="checkbox"/> Yes <input type="checkbox"/>
Have you been involved in an accident prior to your initial check-up or since the last medical fitness examination for seafarers? No <input type="checkbox"/> Yes <input type="checkbox"/> When? Which injury/injuries? Any remaining issues from this injury/these injuries?:	Do you currently suffer from any health problems or are you currently receiving any medical/dental treatment? No <input type="checkbox"/> Yes <input type="checkbox"/> Details:
Are you registered as a handicapped person? No <input type="checkbox"/> Yes <input type="checkbox"/> Degree of disability?:	Do you have any allergies? No <input type="checkbox"/> Yes <input type="checkbox"/> Which?:
Do you take any medication on a regular basis? No <input type="checkbox"/> Yes <input type="checkbox"/> Which?:	Do you smoke? No <input type="checkbox"/> Yes <input type="checkbox"/> Amount per day?:
Do you drink alcohol? No <input type="checkbox"/> Yes <input type="checkbox"/> Occasionally <input type="checkbox"/> daily <input type="checkbox"/> Amount?:	Do you take any drugs? No <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> not any more since:
Have you been treated or operated in a hospital within the last 2 years? No <input type="checkbox"/> Yes <input type="checkbox"/> When? Illness?:	
For female crew members: Are you pregnant? No <input type="checkbox"/> Yes <input type="checkbox"/>	

Are you suffering or have you ever suffered from the following illnesses /abnormalities?

Please answer each question with yes or no. Any answers with yes, please clarify below under remarks.

	yes	no		yes	no		yes	no
1. Visual aid (e.g. glasses or contact lenses)	<input type="checkbox"/>	<input type="checkbox"/>	9. Frequent or severe headache (e.g. migraine, cluster headache)	<input type="checkbox"/>	<input type="checkbox"/>	16. Mental diseases (e.g. depression, psychoses, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>
2. Colour vision deficiency/ weakness	<input type="checkbox"/>	<input type="checkbox"/>	10. Infections (e.g. jaundice (hepatitis), diarrhoea)	<input type="checkbox"/>	<input type="checkbox"/>	17. Dizziness, unconsciousness imbalance	<input type="checkbox"/>	<input type="checkbox"/>
3. Nyctalopia (night blindness)	<input type="checkbox"/>	<input type="checkbox"/>	11. Sexually transmitted diseases (STD)	<input type="checkbox"/>	<input type="checkbox"/>	18. Blood diseases (e.g. Anaemia, Leukaemia, Coagulopathy)	<input type="checkbox"/>	<input type="checkbox"/>
4. Eye disease (e.g. glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	12. Diseases of the genito-urinary system (e.g. bladder/kidney stones, frequent urinary tract infections, haemorrhoids)	<input type="checkbox"/>	<input type="checkbox"/>	19. Cancer (carcinosis)	<input type="checkbox"/>	<input type="checkbox"/>
5. Dental problems, prostheses, implants	<input type="checkbox"/>	<input type="checkbox"/>	13. Diseases of the digestive system (e.g. liver, stomach, gall; blood in the stool)	<input type="checkbox"/>	<input type="checkbox"/>	20. Skin diseases (e.g. psoriasis, eczema)	<input type="checkbox"/>	<input type="checkbox"/>
6. Sleep disturbances	<input type="checkbox"/>	<input type="checkbox"/>	14. Metabolic diseases (e.g. diabetes, overweight, thyroid disease)	<input type="checkbox"/>	<input type="checkbox"/>	21. Hernia	<input type="checkbox"/>	<input type="checkbox"/>
7. Cardiovascular diseases (e.g. high blood pressure, heart surgeries, thrombosis, varicose veins, cardiac arrhythmias, heart attack, cardiac valve disease, embolisms)	<input type="checkbox"/>	<input type="checkbox"/>	15. Diseases of the locomotor system (e.g. broken bones, amputations, endoprotheses, back/joint problems, reduced mobility)	<input type="checkbox"/>	<input type="checkbox"/>	22. Neurological diseases (e.g. convulsions, stroke, multiple sclerosis, Parkinson's disease)	<input type="checkbox"/>	<input type="checkbox"/>
8. Respiratory diseases (e.g. frequent bronchitis, asthma, tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>	16. Ear disorders (e.g. tinnitus, hearing aid, hardness of hearing)	<input type="checkbox"/>	<input type="checkbox"/>	23. Any other diseases that are not listed	<input type="checkbox"/>	<input type="checkbox"/>

Remarks:

Declaration:

I hereby declare that the above mentioned and personally completed details are true, complete and have been given to the best of my knowledge. Omitting any significant medical problems may result in legal action.

place, date

signature

In the case of minors: signature of the person having the custody; the assent applies to any acts of legal significance relating to the medical fitness for sea service.