azb
arbeitsmedizinisches zentrum basel

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? ..... examing physician: ..... Grounds: .....

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

If yes, when? ..... examing 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 familiy (grandparents, parents or siblings) suffers or has suffered from one of the following illnesses:

High blood pressure	☐ no	☐ yes, who?
Diabetes mellitus	☐ no	☐ yes, who?
High blood lipid level	☐ no	☐ yes, who?
Heart attack	☐ no	☐ yes, who?
Stroke	☐ no	☐ yes, who?
Epilepsy	☐ no	☐ yes, who?
Others	☐ no	☐ yes, what and who?

Current health situation

Do you have any health problems currently? ☐ no ☐ yes

If yes, what are they?

.....

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

If yes, for what reasons?

.....

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):

.....

Height and weight? .....cm ..... kg

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).

.....

.....

.....

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