

Pre-Sea Medical History Questionnaire

Personal Information

Full Name

Date of Birth

Nationality

Rank/Position

Contact Number

Medical History

Have you ever had, or have you currently:

☐

Asthma

☐

Diabetes

☐

Epilepsy

☐

Heart Disease

☐

High Blood Pressure

☐

Tuberculosis

☐

Hepatitis

☐

Malaria

☐

Psychiatric Disorders

☐

Other (specify below)

If other, please specify

Surgical History

Have you ever undergone any operations?

If yes, please specify

Allergies

Do you have any allergies (medications, food, etc.)?

If yes, please specify

Current Medications

Are you currently taking any medication?

If yes, please list

Additional Information

Any other relevant medical information:

Date

Signature