

## Medical History Questionnaire – R/V Savannah

This form is voluntary. You may ignore it, complete parts of it, or fill it out fully. It is intended solely for your self-protection at sea, by making your medical history available for reference at Medical Advisory Systems (MAS), 8050 Southern Maryland Blvd., Owings, MD 20736. MAS is the consulting medical service ashore that will be contacted should you have an injury or illness which the limited facilities of the ship are unable to treat satisfactorily.

Newcomers to seagoing should realize that despite constant safety, the ocean presents risks not found on land. The R/V Savannah operates far from port, rarely carries a doctor or any individual with advanced medical expertise, and has very limited medical facilities and supplies. Filing your medical history on this form is one way to enhance your personal safety.

### Medical History Questionnaire

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ JOB TITLE: \_\_\_\_\_

IN CASE OF EMERGENCY, NOTIFY: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

PERSONAL PHYSICIAN OR CLINIC: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

**BLOOD TYPE:**      A      B      AB      O      **RH FACTOR:**      POS      NEG

FAMILY HISTORY: Has anyone in your family ever had (check box if yes):

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	Epilepsy/Seizure

Any other major conditions? \_\_\_\_\_

If you answered yes, please explain: \_\_\_\_\_

**Check the box if you have had or received medical treatment for:**

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Cancer/Tumor
<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	20/20 Vision	<input type="checkbox"/>	Vision Problems
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Fractured Vertebrae	<input type="checkbox"/>	Slipped Disc
<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Mental Breakdown
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	Drug Problems
<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Rash/Skin Trouble
<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Hearing Problems
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	Wrist Problems
<input type="checkbox"/>	Jaundice or Hepatitis				

Date of last tetanus shot: \_\_\_\_\_ Date of recent dental work: \_\_\_\_\_

**Females Only:**       Pregnancy       Menstrual Problems       Breast Lumps

**Males Only:**       Prostate Problems       Penile Discharge       Testicular Lumps

Are you currently under a doctor's care? \_\_\_\_\_ For what problems? \_\_\_\_\_

Physician(s) Name/Address (if different than noted at top of page): \_\_\_\_\_

Please list any surgeries/hospitalizations (reason for and date):

Habits:

Do you or did you smoke? \_\_\_\_\_ How long? \_\_\_\_\_ Packs per day? \_\_\_\_\_

Do you use alcoholic beverages? \_\_\_\_\_ How much/often? \_\_\_\_\_

Do you use or take any drugs? \_\_\_\_\_ What kinds? \_\_\_\_\_

Please list prescription and over the counter medications you take regularly: \_\_\_\_\_

**I authorize MAS to release necessary medical information to health care providers in the event of illness or of injury.**

**Staff/Crew Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_