MARITIME AND PORT AUTHORITY OF SINGAPORE
SHIPPING DIVISION

RECORD OF MEDICAL EXAMINATIONS OF SEAFARER

Part A – to be completed by the Seafarer who is responsible for answering each question accurately.

Seafarer's Name in Full (BLOCK CAPITALS)			Sex: Male/Female
Date of Birth: day/month/year	Place of Birth:	Nationality:	
Type of ID documents: NRIC No. / Passport No.:	Dept: Deck / Engine / Catering / others Rank:	Type of ship:	
Home Address:	Routine and emergency duties:	Trading area: e.g coastal / world wide	

Seafarer's Declarations *(please tick)*

Have you ever had any of the following conditions?

	Yes	No		Yes	No
1. Eye/vision problem			18. Sleep problem		
2. High blood pressure			19. Do you smoke, use alcohol or drugs?		
3. Heart/vascular disease			20. Operation/surgery		
4. Heart Surgery			21. Epilesy/seizures		
5. Varicose veins/piles			22. Dizziness/fainting		
6. Asthma/bronchitis			23. Loss of consciousness		
7. Blood disorder			24. Psychiatric problems		
8. Diabetes			25. Depression		
9. Thyroid problem			26. Attempted suicide		
10. Digestive disorder			27. Loss of memory		
11. Kidney problem			28. Balance problem		
12. Skin Problem			29. Severe headaches		
13. Allergies			30. Ear(hearing, tinnitus/nose/throat problem		
14. Infectious / contagious diseases			31. Restricted mobility		
15. Hernia			32. Back or joint problem		
16. Genital disorder			33. Amputation		
17. Pregnancy			34. Fracture/dislocations		

If you answer "yes" to any of the above questions, please provide details:

Additional questions	**Yes**	**No**
35. Have you ever been signed off as sick or repatriated from a ship?		
36. Have you ever been hospitalized?		
37. Have you ever been declared unfit for sea duty?		

38. Has your medical certificate even been restricted or revoked?		
39. Are you aware that you have any medical problems, diseases or illnesses?		
40. Do you feel healthy and fit to perform the duties of your designated position/occupation?		
41. Are you allergic to any medication?		
42. Are you using any non-prescription or prescription medication?		

If you answer "yes", please list the medications taken, the purpose(s) and the dosage:

I hereby declare that the personal declaration above is a true statement to the best of my knowledge.

_____	_____	_____
Date	Signature of Seafarer	Name and Signature of Witness

I hereby authorize the release of all my previous medical records (including my last Seafarer Medical Certificate) from any health professional, health institutions and public authorities to Dr. _____.

_____	_____	_____
Date	Signature of Seafarer	Name and Signature of Witness

Part B – Result of medical examinations

Eyesight
Use of glasses or contact lenses

☐ No

☐ Yes Type …….. Purpose ……..

Visual Acuity

Unaided			**Aided**		
Right eye	Left eye	Binocular	Right eye	Left eye	Binocular
Distant			Distant		
Near			Near		

Visual fields

	Normal	**Defective**
Right eye		
Left eye		

Colour Vision *(please tick)*

☐ Not tested ☐ Normal ☐ Doubtful ☐ Defective

Hearing

Pure tone and audiometry (threshold values in dB)				
	500 Hz	**1,000 Hz**	**2,000 Hz**	**3,000 Hz**
Right ear				
Left ear				

Speech and whisper test (metres)

	Normal	**Whisper**
Right ear		
Left ear		

Clinical Findings

Height (cm)		Weight (kg)	
Pulse rate (per minute)		Rhythm	
Blood Pressure Systolic (mm Hg)		Diastolic (mm Hg)	
Urinalysis: Glucose :	Protein:	Blood:	

	Normal	**Abnormal**
Head		
Sinus, nose, throat		
Mouth/teeth		
Ears (general)		
Tympanic membrane		
Eyes		
Ophthalmoscopy		
Pupils		
Eye movement		
Lungs and chest		
Breast examination		
Heart		
Skin		
Varicose Vein		
Vascular (inc. pedal pulse)		
Abdomen and viscera		
Hernia		
Anus (not rectal exam)		
G-U system		
Upper and lower extremities		
Spine (C/s, T/S, L/S)		
Neurologic (full/brief)		
Psychiatric		
General appearance		

Chest X-ray

☐ Not performed ☐ Performed on (day/month/year): ……..

Results: ……..……..

Other diagnostic test(s) and result(s):

Test …… Results: ……

Medical practitioner's comments and assessment of fitness, with reasons for any limitations.

Assessment of fitness for service at sea *(please tick)*

On the basis of the seafarer's personal declaration, my clinical examination and diagnostic test results recorded above, I declare the seafarer medically:

☐ Fit for look out duty ☐ Unfit for lookout duty

☐ Visual aid required ☐ Visual aid not required

	Deck Service	Engine Service	Catering Service	Other Service
Fit				
Unfit				

☐ Without restrictions ☐ With restrictions

Description of restrictions (e.g. specific position, type of ship, trading area etc.)

Date	Signature of Medical Practitioner	Medical Practitioner's name, licence number, address

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