An Roinn Iompair, Turasóireachta agus Spóirt, Lána Líosain, Baile Atha Cliath 2

Department of Transport, Tourism and Sport
Leeson Lane,
Dublin 2.

Form. 1

MEDICAL SCREENING QUESTIONNAIRE

TO BE COMPLETED AND SIGNED BY SEAFARER

EMPLOYING COMPANY:

PURPOSE OF EXAMINATION

Pre-employment		Periodic	

Rank

PERSONAL DETAILS

Surname	Other names	Male/Female	Date of Birth

Home Address	Telephone No	Name & Address of Family Doctor	Telephone No
	Mobile		
	E-Mail		

MEDICAL HISTORY

	Yes	No	Comments
Are you at present or have you been at any time in the past 12 months under the care of a Doctor?			
Are you allergic to anything?			
Have you taken tablets or medicines for any reason in the past 12 months?			
Are you a smoker?			
Have you smoked in the past?			
If yes when did you stop? month/year			
How much alcohol do you drink per week? Amount			
Do you take any regular exercise?			
Do you have any impairment, which affects your day to day activities?			
Are you currently pregnant?			
Is there a history of hereditary diseases in your family?			

Have you had or do you suffer from any of the following?	Yes	No	Comments
Heart Trouble, Chest Pains or Palpitations			
Breathlessness or persistent cough			
High Blood Pressure			
Bronchitis / Asthma / Hay Fever			
Pneumonia, collapsed lung or Tuberculosis			
Frequent Nausea, Vomiting, Heartburn, or Indigestion			
Abdominal pain or Stomach Ulcer			
Jaundice, Gallstones, Liver Disease			
Frequent Diarrhoea / Constipation			
Varicose Veins or Hernia			

Have you had or do you suffer from any of the following?	Yes	No	Comments
Piles or Bleeding from back passage			
Bloods Disorders (Anaemia, Leukaemia, Sickle Cell etc)			
Epilepsy, Fits, Dizziness, Unconsciousness, Balance Disorders			
Frequent Headaches or Migraine			
Difficulty with Vision			
Kidney Trouble or difficulty with Urination			
Diabetes			
Rheumatism, Arthritis or Back Trouble			
Skin Disorders			
Nervous / Mental Illness / Sleep Disorder			
Alcohol Dependency or Substance Misuse			
Malignant Disease			
Obstetric / Gynaecological Disorders (females)			
List any injuries and other illness			

HOSPITAL ADMISSIONS

Hospital	Date	Reason

DECLARATION

I declare that the answers given on this form are true to the best of my knowledge and belief:

Signature:_____**Date**:_____

CONSENT

I _____ hereby consent to undergo the following:

1. A seafarer's medical examination under the Merchant Shipping (Medical Examinations) Regulations 2005 (SI No. 701 of 2005).

2. I understand that a drugs and alcohol test may form part of the seafarer's medical assessment if clinically indicated.

3. To the collection of my personal data for the purpose of obtaining a Seafarer Medical Certificate. The Certificate will be issued by the Department of Transport, Tourism and Sport and any information will be used for the purposes of which it was collected only and will be processed and retained in accordance with current data protection legislation.

4. If I am issued with a fail or restricted certificate I understand that I can appeal this decision. I also understand that a Medical Referee will hear my appeal and I will consent to the release of all medical records/files held by either my General Practitioner or Approved Doctor, to the Medical Referee for the purposes of my appeal.

   Seafarer's Signature: _____ Date: _____

   I confirm that I have explained the nature and purpose of the procedure to the above named person and, in case of an appeal I hereby notify you that your notes will be sent to the Medical Referee for the purposes of your appeal.

   Signed _____ Date: _____
   (Approved Doctor)