Voyage #	
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PANGAEA EXPLORATIONS

Medical Screening Questionnaire

Please read:

- Please complete this form fully and openly, as any omission may affect our ability to care for you in the event of a medical emergency;
- This form will be kept for a minimum of one year following the end of your voyage, after which it will be disposed of securely;
- The contents of this form are confidential, and will only be disclosed to third parties with your consent, unless in emergency circumstances to expedite your care;
- Pangaea or their agents cannot be held responsible for medical matters that pre-exist the voyage, and are not disclosed on this questionnaire.

- *Please record details of any medical conditions from which you suffer (continue on the back of this sheet if necessary):*

- *Specifically, have you ever suffered from:*
  - *High blood pressure* *Yes / No*
  - *Heart attacks (myocardial infarctions/coronories)* *Yes / No*
  - *Angina* *Yes / No*
  - *Strokes (cerebral vascular accidents)* *Yes / No*
  - *Jaundice* *Yes / No*
  - *Tuberculosis* *Yes / No*
  - *Rheumatic fever* *Yes / No*
  - *Diabetes* *Yes / No*
  - *Epilepsy* *Yes / No*
  - *Asthma* *Yes / No*
  - *Depression / other mental illness* *Yes / No*
  - *Blood infections (such as hepatitis A, B or C, human immunodeficiency virus (HIV or AIDS)* *Yes / No*
  - *Chronic back pain* *Yes / No*
  - *Kidney stones* *Yes / No*

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- *Cartilage/ligament injuries* *Yes / No*
- *Musculoskeletal injuries* *Yes / No*

- *If yes to any of the above, please record details:*

- *Have you had any operations (please include details and dates):*

- *Please record any medications that you take, either regularly, occasionally or in the past (please include herbal or alternative medicines):*

- *Are you allergic to anything (please include details of circumstances and reactions):*

- *Do you suffer from indigestion or heartburn:*

- *Please record details of any dental work that you may have undergone, together with an assessment of the present state of your teeth:*

- *Do you suffer from seasickness*
  - *What preventative measures do you normally take?*
- *Please detail all immunisations you have had, together with dates (continue overleaf if necessary):*

- *What is your blood group (if known)*
- *What is your height:*
- *What is your weight:*

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DO NOT SCAN. THIS PAGE WILL NOT BE STORED ELECTRONICALLY.

Name: _____

Date of Birth and age: _____

Address: _____

Contact Number: _____

Email: _____

Next of kin: _____

I confirm that I have answered the above questionnaire truthfully and to the best of my ability.

Signed and dated

_____

Crew