



**EMPLOYEE HISTORY**

New Hire

Returning

To be completed by all new hires and returning crewmembers.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Nationality: \_\_\_\_\_

Position: \_\_\_\_\_ Crew # \_\_\_\_\_ Department: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

Address: \_\_\_\_\_ Home Telephone #: \_\_\_\_\_

**HAVE YOU HAD, BEEN TREATED FOR, AND/OR NEED FOLLOW-UP FOR ANY OF THE PROBLEMS LISTED BELOW.  
PLEASE MARK ALL OF THE ONES THAT APPLY TO YOU AND ADD COMMENTS BELOW.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Eye problems                | <input type="checkbox"/> Heart attacks or stroke            | <input type="checkbox"/> Anxiety / Depression     |
| <input type="checkbox"/> Glasses / contacts          | <input type="checkbox"/> Diabetes: Type I / II              | <input type="checkbox"/> Sleeping disorders       |
| <input type="checkbox"/> Headaches / migraines       | <input type="checkbox"/> Thyroid problems                   | <input type="checkbox"/> Eating disorders         |
| <input type="checkbox"/> Dizziness / fainting spells | <input type="checkbox"/> Stomach pains                      | <input type="checkbox"/> Alcohol or Drug abuse    |
| <input type="checkbox"/> Seizures / Epilepsy         | <input type="checkbox"/> Ulcers                             | <input type="checkbox"/> Benign tumors            |
| <input type="checkbox"/> Ear Infections              | <input type="checkbox"/> Acid reflux                        | <input type="checkbox"/> Breast lumps / masses    |
| <input type="checkbox"/> Hearing loss                | <input type="checkbox"/> Chronic vomiting / diarrhea        | <input type="checkbox"/> Cancer Type: _____       |
| <input type="checkbox"/> Hearing aid(s)              | <input type="checkbox"/> Gallbladder                        | <input type="checkbox"/> Anemia / blood disorders |
| <input type="checkbox"/> Nose bleeds                 | <input type="checkbox"/> Arthritis                          | <input type="checkbox"/> Menstrual problems       |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Dislocated or broken bones         | <input type="checkbox"/> Hepatitis: B / C         |
| <input type="checkbox"/> Bronchitis                  | <input type="checkbox"/> Amputations / prosthetics          | <input type="checkbox"/> Kidney stones            |
| <input type="checkbox"/> Pneumonia                   | <input type="checkbox"/> Neck: pain / injury / surgery      | <input type="checkbox"/> Urinary infections       |
| <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Shoulder: pain / injury / surgery  | <input type="checkbox"/> Genital herpes           |
| <input type="checkbox"/> Shortness of breath         | <input type="checkbox"/> Back: pain / injury / surgery      | <input type="checkbox"/> HIV                      |
| <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Hip / Leg: pain / injury / surgery | <input type="checkbox"/> Syphilis / Gonorrhea     |
| <input type="checkbox"/> Hay Fever                   | <input type="checkbox"/> Knee: pain / injury / surgery      | <input type="checkbox"/> Venereal warts           |
| <input type="checkbox"/> Skin problems / rashes      | <input type="checkbox"/> Varicose Veins: Surgery: Y / N     | <input type="checkbox"/> Prostate problems        |
| <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Swelling to arms or legs           | <input type="checkbox"/> Hemorrhoids              |
| <input type="checkbox"/> Heart problems              | <input type="checkbox"/> Hernias of any kind                | <input type="checkbox"/> Rectal bleeding          |
| <input type="checkbox"/> Chest pain                  | <input type="checkbox"/> Mental or nervous disorders        |   |

Please give a short history for any of the boxes you checked: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have read the lists above and marked all that apply. **Signature:** \_\_\_\_\_

Do you have any allergies? Y  N

List allergies: \_\_\_\_\_

Do you smoke? Y  N  If yes, # of cigarettes a day: \_\_\_\_\_

Do you drink alcohol? Y  N  # of drinks a day: \_\_\_\_\_ week: \_\_\_\_\_

Have you ever been in the hospital? Y  N

If yes: why & when? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What operations have you had and when?

\_\_\_\_\_  
\_\_\_\_\_

What medications do you take on a routine basis?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Will you need these medications while on board? Y  N

**For Females Only:**

Date of last Pap? \_\_\_\_\_ Mammogram? \_\_\_\_\_

Do you have problems with your menstrual cycle? Y  N

Date of your last period? \_\_\_\_\_

Are you on birth control? Y  N

Circle type used: IUD / Pill / Injections / Other \_\_\_\_\_

Are you currently pregnant? Y  N

**Carnival**  
**Employee History**

To be completed by all new hires and returning crewmembers.

Name: \_\_\_\_\_ Crew # \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Have you ever been refused a job or military service due to a medical condition, illness or injury? Y  N

Have you ever been discharged from a job or military due to a medical condition, illness or injury? Y  N

Have you ever been given any money for a job related illness or injury? Y  N

What was the injury or illness? \_\_\_\_\_ When did it happen? \_\_\_\_\_

Have you worked for Carnival Cruise Lines in the past? Y  N

When? \_\_\_\_\_

Have you worked for any other cruise line before? Y  N

Name of cruise line and dates of employment? \_\_\_\_\_

Please provide us with a description of any medical problems you have had in the past that were not addressed on these pages below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Proof of MMR Vaccination must be attached to the physical and carried by the crewmember**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The answers on my Employee Physical History forms including all representations concerning my prior medical history are true and correct to the best of my knowledge and belief. I understand that Carnival Cruise Lines will rely on these medical forms in determining whether I am eligible for employment. I also understand that falsification of these records is grounds for termination and may constitute grounds for denial of maintenance and cure benefits in the event that I become ill or injured. I authorize release of any medical information concerning my past, present, or future medical condition by any practitioner or hospital to Carnival Cruise Lines and its accredited representatives.

\_\_\_\_\_  
Applicant/Crewmember Signature

\_\_\_\_\_  
Date

# McCarnival.

## Employee Physical Examination

To be completed by the examining physician: Please circle and check all that apply.

Name: \_\_\_\_\_ Crew # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Vital Signs: Temp: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ BP: L \_\_\_\_\_ R \_\_\_\_\_

<b>Eyes</b>		<b>Breath Sounds</b>		<b>Gastrointestinal</b>		<b>Labs / Tests</b>		<b>Check If Completed</b>			
L: 20/	Corrected	20/	Clear & equal	No	Yes	Hx: Ulcers	Yes	No	<b>BMI = (Body Mass Index)</b>		
R: 20/	Corrected	20/	Wheezing / Rhonci	Yes	No	Acid Reflux	Yes	No	BMI = [weight / (height x height)] x 703		
Color Blindness	Yes	No	Tuberculosis	Yes	No	Abdominal Pains	Yes	No	<b>EKG - Females 45+</b>		
Red / Green			Chest X-ray	Abn	Nor	Nausea / Vomiting	Yes	No	<b>EKG - Males 40+</b>		
Yellow / Blue			<b>Skin</b>			Diarrhea	Yes	No	<b>ALL CREW over 50</b>		
Other:			Warm / Dry / Intact	No	Yes	Constipation	Yes	No	<b>Rectal exam</b>		
Pterygium R / L	Yes	No	Lesions	Yes	No	Bowel sounds	Neg	Pos	Hemoccult for blood	Positive	Negative
Glaucoma	Yes	No	Scars	Yes	No	Hemorrhoids present	Yes	No	<b>Males 50 and over</b>		
Cataracts	Yes	No	Birthmarks	Yes	No	Hernias palpated	Yes	No	PSA	Positive	Negative
Abnormal Vascularity	Yes	No	Jaundice	Yes	No	Hepatomegaly	Yes	No	<b>REQUIRED FOR ALL CREW</b>		<b>Check If Completed</b>
Conjunctivitis	Yes	No	Discolorations	Yes	No	<b>Genitourinary</b>			Glucose		
Exophthalmia	Yes	No	Eczema/Psoriasis	Yes	No	Hx: Kidney stones	Yes	No	CBC		
Retinopathy	Yes	No	Ganglion cyst	Yes	No	Recurrent UTI's	Yes	No	Calcium		
<b>Ears</b>			Lymphomas	Yes	No	Urinary frequency	Yes	No	Sodium		
Active: Otitis media	Yes	No	Tattoos	Yes	No	Pain on urination	Yes	No	Potassium		
Otitis externa	Yes	No	<b>Cardiovascular</b>			Hematuria / Nocturia	Yes	No	BUN (blood urea nitrogen)		
Ruptured Membrane	Yes	No	Hx: Heart disease	Yes	No	Venereal warts	Yes	No	Creatinine		
Tumors / Masses	Yes	No	Palpitations	Yes	No	<b>Musculoskeletal</b>			SGPT/ALT		
Hearing loss	Yes	No	Chest Pain / MI	Yes	No	Osteo arthritis	Yes	No	Bilirubin		
Whisper Test	Abn	Nor	Pacemaker / IACD	Yes	No	Rheumatoid arthritis	Yes	No	Hepatitis B		
<b>Nose</b>			Arrhythmia's	Yes	No	Joint pains	Yes	No	Hepatitis C		
Septal: Deviation	Yes	No	Hypertension	Yes	No	Gout	Yes	No	HIV		
Nasal polyps	Yes	No	Congestive Failure	Yes	No	Muscle: weakness	Yes	No	Urinalysis		
Hx. Epistaxis	Yes	No	Cardiomegaly	Yes	No	Cramps	Yes	No	<b>Urinalysis to include:</b>		<b>Results</b>
Nasal fractures	Yes	No	Cardiomyopathy	Yes	No	Stiffness	Yes	No	Bilirubin		
Heavy snoring	Yes	No	Dyspnea on exertion	Yes	No	Deformities	Yes	No	Urobilinogen		
Tonsillitis	Yes	No	Pedal edema	Yes	No	Deviations	Yes	No	Acetone		
<b>Dental</b>			Varicose Veins	Yes	No	Injury/Pain/Surgery of:			Glucose		
Good hygiene	No	Yes	Homan's Sign	Pos	Neg	Back / Neck	Yes	No	Protein		
Cavities	Yes	No	<b>Males</b>			Shoulder/Arm/Wrist	Yes	No	Blood		
Gingivitis	Yes	No	Epididymitis	Yes	No	Knee / Leg / Ankle	Yes	No	Nitrite		
Mouth sores	Yes	No	Orchitis	Yes	No	<b>Neuro</b>			Leukocytes		
<b>Respiratory</b>			Hypo / Hyperspadias	Yes	No	Cranial Nerves 1 - 12	Abn	Nor	pH		
Hx: Asthma	Yes	No	Varicocele	Yes	No	Peripheral nerves	Abn	Nor	Specific gravity		
Bronchitis	Yes	No	Scrotal Hernia	Yes	No	Hx: Tremors / Seizure	Yes	No	<b>Urine drug screen</b>		<b>Attach Results</b>
Emphysema	Yes	No	Prostatomegaly	Yes	No	Vertigo / Ataxia	Yes	No	<b>To include:</b>		
Pneumonia	Yes	No	<b>Females</b>			Shunts	Yes	No	Amphetamines		
Constant cough	Yes	No	Amenorrhea	Yes	No	<b>Emotional</b>			Cocaine		
Sputum production	Yes	No	Dysmenorrhea	Yes	No	Hx: Insomnia	Yes	No	Opiates		
<b>Endocrine</b>			Menorrhagia	Yes	No	Depression	Yes	No	Phencyclidine		
Diabetes (Type I / II)	Yes	No	Menopause	Yes	No	Anxiety	Yes	No	THC		
Polyuria / Polydipsia	Yes	No	Vaginal Discharge	Yes	No	Hallucinations	Yes	No	<b>F&amp;B handlers only</b>		
Thyroid problems	Yes	No	Breast exam: Lumps	Pos	Neg	Eating disorders	Yes	No	Stool: Salmonella	Positive	Negative
									Shigella	Positive	Negative
									Ova/Parasites	Positive	Negative

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Date of exam: \_\_\_\_\_ Doctor Initials \_\_\_\_\_

**Carnival**  
**Employee Physical Examination**  
To be completed by the examining physician

Name: \_\_\_\_\_ Crew # \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Please document and comment on all abnormal test results and physical findings in the space provided below.**

A copy of all the applicant's lab results must accompany these completed medical forms. Please document on general appearance and mental attitude as needed. Please print clearly.

**Last date of menstrual period: \_\_\_\_\_ If it has been greater than 28 days since the last menstrual period please do pregnancy test and attach result. If urine pregnancy dipstick test performed in the office please circle result: positive / negative.**

**Proof of MMR Vaccination must be attached to the physical and carried by the crewmember**

I certify that I have examined the above named applicant according to the medical standards provided by Carnival Cruise Lines and can attest this applicant has completed all required tests and with a full physical examination, I have identified no reportable deficiencies, other than those listed above.

Printed name of examining physician: \_\_\_\_\_ Signature: \_\_\_\_\_

Address of examining physician: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of exam: \_\_\_\_\_

Applicant Name: \_\_\_\_\_ Stamp: \_\_\_\_\_