

外国人 体格检查表

FOREIGNER PHYSICAL EXAMINATION FORM

姓名 Name		性别 Sex	<input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	出生日期 Birthday		照片 (加盖检查单位印章)	
现在通讯地址 Present mailing address							Photo (Stamped Official Stamp)
国籍或地区 Nationality (or Area)		出生地 Birth place		血型 Blood type			
过去是否患有下列疾病：(每项后面请回答“否”或“是”) Have you ever had any of the following diseases? (Each item must be answered "Yes" or "No")							
班疹 伤寒 小儿麻痹症 白喉 猩红热 回归热 伤寒和付伤寒 流行性脑脊髓膜炎	Typhus fever Poliomyelitis Diphtheria Scarlet fever Relapsing fever Typhoid and paratyphoid fever Epidemic cerebrospinal meningitis	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes	菌痢 布氏杆菌病 病毒性肝炎 产褥期链球菌感染 菌感染	Bacillary dysentery Brucellosis Viral hepatitis Puerperal streptococcus infection Bacterial infection	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes		
是否患有下列危及公共秩序和安全的病症：(每项后面请回答“否”或“是”) Do you have any of the following diseases or disorders endangering the public order and security? (Each item must be answered "Yes" or "No")							
毒物瘾 精神错乱 精神病	Toxicomania Mental confusion Psychosis:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes	躁狂型 妄想型 幻觉型	Manic psychosis Paranoid psychosis Hallucinatory	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes		
身高 Height	厘米 CM	体重 Weight	公斤 Kg	血压 Blood pressure	毫米汞柱 mmHg		
发育情况 Development		营养情况 Nourishment		颈部 Neck			
视力 左 L _____ Vision 右 R _____		矫正视力 左 L _____ Corrected vision 右 R _____		眼 Eyes			
辨色力 Colour sense		皮肤 Skin		淋巴结 Lymph nodes			
耳 Ears		鼻 Nose		扁桃体 Tonsils			
心 Heart		肺 Lungs		腹部 Abdomen			

脊柱 Spine		四肢 Extremities		神经系统 Nervous system																	
其他所见 Other abnormal findings																					
胸部 X 线 检查结果 (附检查报告单) Chest X-ray exam (attached chest X-ray report)				心电图 ECC																	
化实验室检查 (包括艾滋病、 梅毒等血清学检查) Laboratory exam (attached test report of AIDS, Syphilis etc)																					
<p style="text-align: center;">未发现患有下列检疫传染病和危害公共健康的疾病:</p> <p style="text-align: center;">None of the following diseases of disorders found during the present examination.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">霍乱</td> <td style="width: 25%;">Cholera</td> <td style="width: 25%;">性病</td> <td style="width: 25%;">Venereal Disease</td> </tr> <tr> <td>黄热病</td> <td>Yellow fever</td> <td>肺结核</td> <td>Lung tuberculosis</td> </tr> <tr> <td>鼠疫</td> <td>Plague</td> <td>艾滋病</td> <td>AIDS</td> </tr> <tr> <td>麻风</td> <td>Leprosy</td> <td>精神病</td> <td>Psychosis</td> </tr> </table>						霍乱	Cholera	性病	Venereal Disease	黄热病	Yellow fever	肺结核	Lung tuberculosis	鼠疫	Plague	艾滋病	AIDS	麻风	Leprosy	精神病	Psychosis
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意 见 Suggestion 医师签字 Signature of physician		检查单位盖章 Official Stamp 日期 Date																			