

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 Birth Day-Month-Year		照片 (加盖检查单位印章) Photo (Stamped Official Stamp)
现在通讯地址 Present mailing address					血型 Blood type	
国籍或地区 Nationality (or Area)		出生地址 Birth Place				
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”)						
斑疹伤寒 Typhus fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	菌痢 Bacillary dysentery	<input type="checkbox"/> No <input type="checkbox"/> Yes			
小儿麻痹症 Poliomyelitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	布氏杆菌病 Brucellosis	<input type="checkbox"/> No <input type="checkbox"/> Yes			
白喉 Diphtheria	<input type="checkbox"/> No <input type="checkbox"/> Yes	病毒性肝炎 Viral hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes			
猩红热 Scarlet fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	产褥期链球菌 Puerperal streptococcus	<input type="checkbox"/> No <input type="checkbox"/> Yes			
回归热 Relapsing fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	感染 infection	<input type="checkbox"/> No <input type="checkbox"/> Yes			
伤寒和付伤寒 Typhoid and paratyphoid fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	菌感染 infection	<input type="checkbox"/> No <input type="checkbox"/> Yes			
流行性脑脊髓膜炎 Epidemic cerebrospinal meningitis	<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 Toxicomania	<input type="checkbox"/> No <input type="checkbox"/> Yes				
精神错乱 Mental confusion	<input type="checkbox"/> No <input type="checkbox"/> Yes				
精神病 Psychosis	躁狂型 Manic Psychosis	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	妄想型 Paranoid Psychosis	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	幻觉型 Hallucinatory Psychosis	<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 Vision	左 L _____ 右 R _____	矫正视力 Corrected Vision	左 L _____ 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 ECG																		
化验室检查 (包括艾滋病、梅毒等血 清学检查) Laboratory exam (Attached test report of AIDS, Syphilis etc.)																					
<p>未发现患有下列检疫传染病和危害公共健康的疾病： None of the following diseases of disorders found during the present examination.</p> <table border="0"> <tr> <td>霍乱</td> <td>Cholera</td> <td>性病</td> <td>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		检查单位盖章 Official Stamp																			
医师签字 Signature of physician		日期 Date																			