附件

外国人体格检查记录表

FOREIGNER PHYSICAL EXAMINATION FORM

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 姓名Name |  | 性别Sex | 男Male女Female | 出生日期Birthday |  | 照片（加盖检查单位印章）Photo（Stamped OfficialStamp） |
| 现在通讯地址Present mailing address |  |
| 国籍或地区Nationality(or Area) |  | 出生地Birthplace |  | 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”）斑疹 伤寒 Typhus fever No Yes 菌 痢 Bacillary dysentery No Yes小儿麻痹症 Poliomyelitis No Yes 布氏杆菌病 Brucellosis No Yes白 喉 Diphtheria No Yes 病毒性肝炎 Viral hepatitis No Yes猩 红 热 Scarlet fever No Yes 产褥期链球 Puerperal steptococcus No Yes回 归 热 Relapsing fever No Yes 菌 感 染 No Yes伤寒和付伤寒 Typhoid and paratyphoid No Yes流行性脑脊髓膜炎 Epidemic cerebrospinal meningitis No 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 of disorders endangering the public order and security ?（Each item must be answered “Yes” or “No”）毒物瘾 Toxicomania……………………………………………… No Yes精神错乱 Mental confusion………………………………………… No Yes精神病 Psychosis………………………………………………… No Yes躁狂型 Manic paychosis………………………………………… No Yes妄想型 Paranoid psychosis………………………………………… No Yes幻觉型 Hallucinatory……………………………………………… No Yes |
| 身高 厘米Height CM  | 体重 公斤Weight Kg | 血压 毫米汞柱Blood pressure 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ECG |  |
| 化验室检查（包括艾滋病、梅毒等血清学检查）Laboratory exam(attached test report ofAIDS,Syphilis etc) |  |
| 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  |
|  意 见 检查单位盖章 Suggestion Official Stamp 医师签字 日期 Signature of physician Date |