

外国人体格检查记录

PHYSICAL EXAMINATION RECORD FOR FOREIGNER

姓名 Name		性别 ☐ 男 Male Sex ☐ 女 Female	出生日期 ____年__月__日 Date of Birth y. ____m. ____d. ____	照片 photo (put hospital seal across the photo)
现在通讯地址 Present mailing address			血型 Blood Type	
国籍 Nationality		出生地 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	☐ No ☐ Yes	细菌性痢疾 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	产褥期链球菌 Puerperal streptococcus	☐ No ☐ Yes	
回归热 Relapsing fever	☐ No ☐ Yes	感染 infection	☐ No ☐ Yes	
伤寒和副伤寒 Typhoid and paratyphoid fever	☐ 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 or disorders endangering the public order and secure? (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: 躁狂型 Manic psychosis	☐ No ☐ Yes			
妄想型 Paranoid psychosis	☐ No ☐ Yes			
幻觉型 Hallucinatory psychosis	☐ No ☐ Yes			
身高/Height (厘米/ cm)		体重/ Weight (公斤/ kg)		血压/pressure Blood(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/Color sense		皮肤/Skin		淋巴结/Lymph nodes
耳/Ears		鼻/Nose		扁桃体/Tonsils
心/Heart		肺 /Lungs		腹部/Abdomen

编号: 42 (19×27cm)

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/Chest X-ray exam		心电图/ECG
化验室检查(包括艾滋病、梅毒血清学诊断)/Laboratory Exam (HIV, Syphilis Serodiagnosis)	附上对以下项目的化验室报告: Please attach the results and data sheets for the following items:AIDS.,Syphilis,ALT.,AST.,T-BIL.,and HBsAG.	
未发现患有以下检疫传染病和危害公共健康的疾病: None of the following diseases or disorders found during the present examination.		
霍乱 Cholera 黄热病 Yellow fever 鼠疫 Plague 麻风 Leprosy	性病 Venereal Disease 开放性肺结核 Opening lung tuberculosis 艾滋病 AIDS 精神病 Psychosis	
意见 Suggestion	检查单位盖章 Official Stamp	
医师签字 Signature of physician	日期 Date	