

# 外国人体格检查记录

## Physical Examination Record for Foreigner

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  Photo																																																								
现在通讯地址 Present Mailing Address					血型 Blood type																																																									
国籍 Nationality		出生地址 Birth Place																																																												
<p>过去是否患有下列疾病（每项后面请回答“否”或“是”）</p> <p><i>Have you ever had any of the following diseases?</i></p> <p><i>(Each item must be answered "Yes" or "No")</i></p>																																																														
<table style="width: 100%; border: none;"> <tr> <td style="width: 15%;">斑疹伤寒</td> <td style="width: 15%;">Typhus fever</td> <td style="width: 10%;"><input type="checkbox"/>No</td> <td style="width: 10%;"><input type="checkbox"/>Yes</td> <td style="width: 15%;">菌痢</td> <td style="width: 15%;">Bacillary dysentery</td> <td style="width: 10%;"><input type="checkbox"/>No</td> <td style="width: 10%;"><input type="checkbox"/>Yes</td> </tr> <tr> <td>小儿麻痹症</td> <td>Poliomyelitis</td> <td><input type="checkbox"/>No</td> <td><input type="checkbox"/>Yes</td> <td>布氏杆菌病</td> <td>Brucellosis</td> <td><input type="checkbox"/>No</td> <td><input type="checkbox"/>Yes</td> </tr> <tr> <td>白喉</td> <td>Diphtheria</td> <td><input type="checkbox"/>No</td> <td><input type="checkbox"/>Yes</td> <td>病毒性肝炎</td> <td>Viral hepatitis</td> <td><input type="checkbox"/>No</td> <td><input type="checkbox"/>Yes</td> </tr> <tr> <td>猩红热</td> <td>Scarlet fever</td> <td><input type="checkbox"/>No</td> <td><input type="checkbox"/>Yes</td> <td>产褥期链球菌感染</td> <td></td> <td></td> <td></td> </tr> <tr> <td>回归热</td> <td>Relapsing fever</td> <td><input type="checkbox"/>No</td> <td><input type="checkbox"/>Yes</td> <td>产褥期链球菌感染</td> <td>Puerperal streptococcus infection</td> <td><input type="checkbox"/>No</td> <td><input type="checkbox"/>Yes</td> </tr> <tr> <td colspan="2">伤寒和副伤寒</td> <td colspan="2">Typhoid and paratyphoid fever</td> <td colspan="2"></td> <td><input type="checkbox"/>No</td> <td><input type="checkbox"/>Yes</td> </tr> <tr> <td colspan="2">流行性脑脊髓膜炎</td> <td colspan="2">Epidemic cerebrospinal meningitis</td> <td colspan="2"></td> <td><input type="checkbox"/>No</td> <td><input type="checkbox"/>Yes</td> </tr> </table>							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	产褥期链球菌感染				回归热	Relapsing fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	产褥期链球菌感染	Puerperal streptococcus infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes	伤寒和副伤寒		Typhoid and paratyphoid fever				<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
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<p>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”）</p> <p><i>Do you have any of the following diseases or disorders endangering the public order and security?</i></p> <p><i>(Each item must be answered "Yes" or "No")</i></p>																																																														
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身高 Height	cm	体重 Weight	kg	血压 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																								
其它所见 Other abnormal findings																										
胸部 X 线 检查 Chest X-ray Exam.		心 电 图  E C G																								
化验室检查 包括血清学诊断 Laboratory Exam. (Serodiagnosis)																										
<p style="text-align: center;">是否发现患有下列检疫传染病和危害公共健康的疾病：  <i>Do you have any of the following diseases or disorders found during the present examination?</i>  <i>(Each item must be answered "Yes" or "No")</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 15%;">霍 乱</td> <td style="width: 15%;">Cholera</td> <td style="width: 15%;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td style="width: 15%;">性 病</td> <td style="width: 15%;">Venereal Disease</td> <td style="width: 15%;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>黄 热 病</td> <td>Yellow fever</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>开放性肺结核</td> <td>Opening lung tuberculosis</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>鼠 疫</td> <td>Plague</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>艾 滋 病</td> <td>AIDS</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>麻 风</td> <td>Leprosy</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>精 神 病</td> <td>Psychosis</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> </table>			霍 乱	Cholera	<input type="checkbox"/> No <input type="checkbox"/> Yes	性 病	Venereal Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	黄 热 病	Yellow fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	开放性肺结核	Opening lung tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	鼠 疫	Plague	<input type="checkbox"/> No <input type="checkbox"/> Yes	艾 滋 病	AIDS	<input type="checkbox"/> No <input type="checkbox"/> Yes	麻 风	Leprosy	<input type="checkbox"/> No <input type="checkbox"/> Yes	精 神 病	Psychosis	<input type="checkbox"/> No <input type="checkbox"/> Yes
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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																									