



ALL FIELDS ARE REQUIRED
所有项目均为必填

外国人体格检查表

FOREIGNER PHYSICAL EXAMINATION FORM

姓名 Name	Full Name in the Latest Passport	性别 Sex	<input checked="" type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	出生日期 Birthday	2002.03.20	照片 (加盖检查单位印章) Photo (Official Stamp) HOSPITAL	
现在通讯地址 Present mailing address		XXX, XXX, XXXXX, XXXX					
国籍或地区 Nationality (or Area)	CHINA	出生地 Birth place	XXX	血型 Blood type	A		
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 Typhus fever	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	菌 痢 Bacillary dysentery	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	小儿麻痹症 Poliomyelitis	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	布氏杆菌病 Brucellosis	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
白 喉 Diphtheria	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	病毒性肝炎 Viral hepatitis	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	猩 红 热 Scarlet fever	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	产褥期链球 Puerperal streptococcus infection	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
回 归 热 Relapsing fever	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	菌 感 染 Bacterial infection	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	伤寒和付伤寒 Typhoid and paratyphoid fever	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	流行性脑脊膜炎 Epidemic cerebrospinal meningitis	<input checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes	精神错乱 Mental confusion	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	精神病 Psychosis: 躁狂型 Manic psychosis	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	妄想型 Paranoid psychosis	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
		幻觉型 Hallucinatory	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
身高 Height	xxx 厘米 CM	体重 Weight	xxx 公斤 Kg	血压 Blood pressure	xxx 毫米汞柱 mmHg		
发育情况 Development	Normal	营养情况 Nourishment	Normal	颈部 Neck	Normal		
视力 左 L Vision 右 R	xxx xxx	矫正视力 左 L Corrected vision 右 R	xxx xxx	眼 Eyes	Normal		
辨色力 Colour sense	Normal	皮肤 Skin	Normal	淋巴结 Lymph nodes	Normal		
耳 Ears	Normal	鼻 Nose	Normal	扁桃体 Tonsils	Normal		
心 Heart	Normal	肺 Lungs	Normal	腹部 Abdomen	Normal		

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脊柱 Spine	Normal	四肢 Extremities	Normal	神经系统 Nervous system	Normal																								
其他所见 Other abnormal findings	N/A																												
胸部 X 线 检查结果 (附检查报告单) Chest X-ray exam (attached chest X-ray report)	Chest organs without pathologies	心电图 ECC		Normal																									
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)	AIDS negative Syphilis negative HIV negative HBsAg negative Anti-HCV negative																												
<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>No/none</td> <td>性病</td> <td>Venereal Disease</td> <td>No/none</td> </tr> <tr> <td>黄热病</td> <td>Yellow fever</td> <td>No/none</td> <td>肺结核</td> <td>Lung tuberculosis</td> <td>No/none</td> </tr> <tr> <td>鼠疫</td> <td>Plague</td> <td>No/none</td> <td>艾滋病</td> <td>AIDS</td> <td>No/none</td> </tr> <tr> <td>麻风</td> <td>Leprosy</td> <td>No/none</td> <td>精神病</td> <td>Psychosis</td> <td>No/none</td> </tr> </table>						霍乱	Cholera	No/none	性病	Venereal Disease	No/none	黄热病	Yellow fever	No/none	肺结核	Lung tuberculosis	No/none	鼠疫	Plague	No/none	艾滋病	AIDS	No/none	麻风	Leprosy	No/none	精神病	Psychosis	No/none
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意见 Suggestion	He/She is physically and mentally fit/healthy.																												
医师签字 Signature of physician	Signature of physician		日期 Date	20.03.2026																									