

# 外国人体格检查表

## FOREIGNER PHYSICAL EXAMINATION FORM

|   |  |   |  |                                  |                     |  |                   |  |                         |  |  |  |  |                       |  |                   |  |  |  |  |                |  |                       |  |  |  |  |                        |  |   |  |  |  |                             |                       |  |       |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|---|--|----------------------------------|---------------------|--|-------------------|--|-------------------------|--|--|--|--|-----------------------|--|-------------------|--|--|--|--|----------------|--|-----------------------|--|--|--|--|------------------------|--|---|--|--|--|-----------------------------|-----------------------|--|-------|--|--|--|--|--------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 姓名<br>Name  |  | 性别<br>Sex                               | <input type="checkbox"/> 男 Male<br><input type="checkbox"/> 女 Female | 出生日期<br>Birth Day - Month - Year |                     | 照 片<br>(加盖检查<br>单位印章<br><br>Photo<br>(stamped<br>Official Stamp) |                   |  |                         |  |  |  |  |                       |  |                   |  |  |  |  |                |  |                       |  |  |  |  |                        |  |   |  |  |  |                             |                       |  |       |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 现在通讯地址<br>Present mailing address   |  |   |  |                                  | 血型<br>Blood<br>type |  |                   |  |                         |  |  |  |  |                       |  |                   |  |  |  |  |                |  |                       |  |  |  |  |                        |  |   |  |  |  |                             |                       |  |       |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 国籍或地区<br>Nationality<br>(or Area)   |  | 出生地址<br>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>Have you ever had any of the following diseases?<br/>(Each item must be answered “yes” or “No”)</p>   |  |   |  |                                  |                     |  |                   |  |                         |  |  |  |  |                       |  |                   |  |  |  |  |                |  |                       |  |  |  |  |                        |  |   |  |  |  |                             |                       |  |       |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <table style="width: 100%; border: none;"> <tr> <td style="width: 15%;">斑疹伤寒 Typhus fever</td> <td style="width: 15%;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td style="width: 15%;">菌 痢 Bacillary dysentery</td> <td style="width: 15%;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td colspan="3"></td> </tr> <tr> <td>小儿麻痹症 Poliomyelitis</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>布氏杆菌病 Brucellosis</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td colspan="3"></td> </tr> <tr> <td>白 喉 Diphtheria</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>病毒性肝炎 Viral hepatitis</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td colspan="3"></td> </tr> <tr> <td>猩 红 热 Scarlet fever</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>产褥期链球 Puerperal streptococcus infection</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td colspan="3"></td> </tr> <tr> <td>回 归 热 Relapsing fever</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>菌 感 染</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td colspan="3"></td> </tr> <tr> <td>伤寒和付伤寒 Typhoid and paratyphoid fever</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td colspan="5"></td> </tr> <tr> <td>流行性脑脊髓膜炎 Epidemic cerebrospinal meningitis</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td colspan="5"></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 Puerperal streptococcus infection | <input type="checkbox"/> No <input type="checkbox"/> Yes |  |  |                             | 回 归 热 Relapsing fever | <input type="checkbox"/> No <input type="checkbox"/> Yes | 菌 感 染 | <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 |  |  |  |  |  | 流行性脑脊髓膜炎 Epidemic cerebrospinal meningitis | <input type="checkbox"/> No <input type="checkbox"/> Yes |  |  |  |  |  |
| 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 Puerperal streptococcus infection | <input type="checkbox"/> No <input type="checkbox"/> Yes             |                                  |                     |  |                   |  |                         |  |  |  |  |                       |  |                   |  |  |  |  |                |  |                       |  |  |  |  |                        |  |   |  |  |  |                             |                       |  |       |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 回 归 热 Relapsing fever   | <input type="checkbox"/> No <input type="checkbox"/> Yes | 菌 感 染                                   | <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 |   |  |                                  |                     |  |                   |  |                         |  |  |  |  |                       |  |                   |  |  |  |  |                |  |                       |  |  |  |  |                        |  |   |  |  |  |                             |                       |  |       |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
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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>Do you have any of the following diseases or disorders endangering the public order and security?<br/>(Each item must be answered “yes” or “No”)</p>  |  |   |  |                                  |                     |  |                   |  |                         |  |  |  |  |                       |  |                   |  |  |  |  |                |  |                       |  |  |  |  |                        |  |   |  |  |  |                             |                       |  |       |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <table style="width: 100%; border: none;"> <tr> <td style="width: 15%;">毒物瘾 Toxicomania</td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>精神错乱 Mental confusion</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td rowspan="3">精神病 Psychosis:</td> <td>躁狂型 Manic Psychosis</td> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>妄想型 Paranoid psychosis</td> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>幻觉型 Hallucinatory psychosis</td> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> </table>  |  |   |  |                                  |                     |  | 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 |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 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<br>Height  | 厘米<br>CM   | 体重<br>Weight                            | 公斤<br>kg   | 血压<br>Blood pressure             | 毫米汞柱<br>mmHg        |  |                   |  |                         |  |  |  |  |                       |  |                   |  |  |  |  |                |  |                       |  |  |  |  |                        |  |   |  |  |  |                             |                       |  |       |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 发育情况<br>Development   |  | 营养情况<br>Nourishment                     |  | 颈部<br>Neck                       |                     |  |                   |  |                         |  |  |  |  |                       |  |                   |  |  |  |  |                |  |                       |  |  |  |  |                        |  |   |  |  |  |                             |                       |  |       |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 视力<br>Vision  | 左 L _____<br>右 R _____                                   | 矫正视力<br>Corrected vision                | 左 L _____<br>右 R _____   | 眼<br>Eyes                        |                     |  |                   |  |                         |  |  |  |  |                       |  |                   |  |  |  |  |                |  |                       |  |  |  |  |                        |  |   |  |  |  |                             |                       |  |       |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 辨色力<br>Colour senses  |  | 皮肤<br>Skin                              |  | 淋巴结<br>Lymph nodes               |                     |  |                   |  |                         |  |  |  |  |                       |  |                   |  |  |  |  |                |  |                       |  |  |  |  |                        |  |   |  |  |  |                             |                       |  |       |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 耳<br>Ears   |  | 鼻<br>Nose                               |  | 扁桃体<br>Tonsils                   |                     |  |                   |  |                         |  |  |  |  |                       |  |                   |  |  |  |  |                |  |                       |  |  |  |  |                        |  |   |  |  |  |                             |                       |  |       |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 心<br>Heart  |  | 肺<br>Lungs                              |  | 腹部<br>Abdomen                    |                     |  |                   |  |                         |  |  |  |  |                       |  |                   |  |  |  |  |                |  |                       |  |  |  |  |                        |  |   |  |  |  |                             |                       |  |       |  |  |  |  |                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |                    |                           |  |             |                      |                  |                       |            |            |             |                 |
|--|--|--------------------|---------------------------|--|-------------|----------------------|------------------|-----------------------|------------|------------|-------------|-----------------|
| 脊 柱<br>Spine   |  | 四 肢<br>Extremities | 神 经 系 统<br>Nervous system |  |             |                      |                  |                       |            |            |             |                 |
| 其它所见<br>Other abnormal findings  |  |                    |                           |  |             |                      |                  |                       |            |            |             |                 |
| 胸部 X 线<br>检查结果<br>(附检查报告单)<br>Chest X - ray<br>exam<br>(attached<br>chest X - ray<br>report)   |  |                    | 心电图<br>ECG                |  |             |                      |                  |                       |            |            |             |                 |
| 化 验 室 检 查<br>(包括艾滋病、梅毒等血清学检查)<br>Laboratory exam<br>(Attached test<br>report of AIDS,<br>Syphilis etc)   |  |                    |                           |  |             |                      |                  |                       |            |            |             |                 |
| <p style="text-align: center;">未发现患有下列检疫传染病和危害公共健康的疾病：<br/>None of the following diseases of disorders found during the present examination.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">霍 乱 Cholera</td> <td style="width: 50%;">性 病 Venereal Disease</td> </tr> <tr> <td>黄热病 Yellow fever</td> <td>肺结核 Lung tuberculosis</td> </tr> <tr> <td>鼠 疫 Plague</td> <td>艾 滋 病 AIDS</td> </tr> <tr> <td>麻 风 Leprosy</td> <td>精 神 病 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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| 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<br>Suggestion  | 检查单位盖章<br>Official Stamp<br><br><br><br><br>医师签字<br>Signature of physician<br><br><br><br>日期<br>Date |                    |                           |  |             |                      |                  |                       |            |            |             |                 |