

境外人员体格检查记录

PHYSICAL EXAMINATION RECORD FOR FOREIGNERS

姓名 Name		性别 Sex	<input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	出生日期 Birth Day-Month-Year	血型 Blood type
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过去是否患有下列疾病：(每项后面请回答“是”或“否”)

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 产褥期链球菌 Puerperal streptococcus infection

回 归 热 Relapsing fever No Yes

伤寒和付伤寒 Typhoid and paratyphoid fever No Yes

流行性脑脊髓膜炎 Epidemic cerebrospinal meningitis No Yes

其他传染疾病 Other infectious Diseases 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“是”或“否”)

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 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

其他精神疾病 Other psycho-related illnesses No Yes

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 or disorders found during the present examination

霍 乱 Cholera	性 病 Venereal Disease
黄 热 病 Yellow fever	开放性肺结核 Opening lung tuberculosis
鼠 疫 Plagus	爱 滋 病 AIDS
麻 风 Leprosy	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