

交 换 生 健 康 体 检 表

EXCHANGE STUDENT PHYSICAL EXAMINATION FORM

姓名 Name		性别 Sex	☐ 男 Male ☐ 女 Female	出生日期 Birthday		照片 (加盖检查单位印章) Photo (Stamped Official Stamp)																																										
现在通讯地址 Present mailing address																																																
国籍或地区 Nationality (or Area)		出生地 Birth place		血型 Blood type																																												
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”) <table border="0"> <tr> <td>班疹 伤寒</td> <td>Typhus fever</td> <td>☐ No ☐ Yes</td> <td>菌 痢</td> <td>Bacillary dysentery</td> <td>☐ No ☐ Yes</td> </tr> <tr> <td>小儿麻痹症</td> <td>Poliomyelitis</td> <td>☐ No ☐ Yes</td> <td>布氏杆菌病</td> <td>Brucellosis</td> <td>☐ No ☐ Yes</td> </tr> <tr> <td>白 喉</td> <td>Diphtheria</td> <td>☐ No ☐ Yes</td> <td>病毒性肝炎</td> <td>Viral hepatitis</td> <td>☐ No ☐ Yes</td> </tr> <tr> <td>猩 红 热</td> <td>Scarlet fever</td> <td>☐ No ☐ Yes</td> <td>产褥期链球</td> <td>Puerperal streptococcus infection</td> <td></td> </tr> <tr> <td>回 归 热</td> <td>Relapsing fever</td> <td>☐ No ☐ Yes</td> <td>菌 感 染</td> <td></td> <td>☐ No ☐ Yes</td> </tr> <tr> <td>伤寒和付伤寒</td> <td colspan="2">Typhoid and paratyphoid fever</td> <td colspan="2"></td> <td>☐ No ☐ Yes</td> </tr> <tr> <td>流行性脑脊髓膜炎</td> <td colspan="2">Epidemic cerebrospinal meningitis</td> <td colspan="2"></td> <td>☐ No ☐ Yes</td> </tr> </table>							班疹 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	Puerperal streptococcus infection		回 归 热	Relapsing fever	☐ No ☐ Yes	菌 感 染		☐ 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
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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”) <table border="0"> <tr> <td>毒物瘾</td> <td>Toxicomania</td> <td>☐ No ☐ Yes</td> </tr> <tr> <td>精神错乱</td> <td>Mental confusion</td> <td>☐ No ☐ Yes</td> </tr> <tr> <td>精神病</td> <td>Psychosis: 躁狂型</td> <td>Manic psychosis ☐ No ☐ Yes</td> </tr> <tr> <td></td> <td>妄想型</td> <td>Paranoid psychosis ☐ No ☐ Yes</td> </tr> <tr> <td></td> <td>幻觉型</td> <td>Hallucinatory ☐ No ☐ Yes</td> </tr> </table>							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 ☐ No ☐ Yes																											
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身高 Height	厘米 CM	体重 Weight	公斤 Kg	血压 Blood pressure	毫米汞柱 mmHg																																											
发育情况 Development		营养情况 Nourishment		颈部 Neck																																												
视力 左 L_____		矫正视力 左 L_____		眼 Eyes																																												
Vision 右 R_____		Corrected vision 右 R_____																																														
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																	
其他所见 Other abnormal findings																					
胸部 X 线 检查结果 (附检查报告单) Chest X-ray exam (attached chest X-ray report)			心电图 ECC																		
化验室检查 (包括艾滋病、 梅毒等血清学检查) Laboratory exam (attached test report of AIDS, Syphilis etc)																					
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. <table><tr><td>霍乱</td><td>Cholera</td><td>性病</td><td>Venereal Disease</td></tr><tr><td>黄热病</td><td>Yellow fever</td><td>肺结核</td><td>Lung tuberculosis</td></tr><tr><td>鼠疫</td><td>Plague</td><td>艾滋病</td><td>AIDS</td></tr><tr><td>麻风</td><td>Leprosy</td><td>精神病</td><td>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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意 见 Suggestion		检查单位盖章 Official Stamp																			
医师签字 Signature of physician		日期 Date																			