西 安 市 体 格 检 查 表

年 月 日

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓 名 | |  | | 性别 | |  | | | 出 | | | 年 月 日 | | | | | 实足年龄 | |  | 半  身  脱  帽  相  片  医院盖骑缝印 |
| 生 | | |
| 文化程度 | |  | | | | | | | | | | | | | 婚否 | |  | | |
| 籍 贯 | | 省 | | | | | | 市 | 现住地址 | | | |  | | | | | | |
| 县 |
| 所在学校或  工作单位 | |  | | | | | | | | | | | | | | | | | |
| 既往病史 | |  | | | | | | | | | | | | | | | | | |
| 家庭病史 | |  | | | | | | | | | | | | | | | | | |
| 五  官  科 | 眼 | 视力 | 左 | | | | 矫正  视力 | | | 左 | | | | 辨色力 | |  | | | | 医生意见  签 字 |
| 右 | | | | 右 | | | |
| 砂眼 | 左 | | | | 其它眼病 | | |  | | | | | | | | | |
| 右 | | | |
| 耳 | 听 力 | 左 | | | | 耳 疾 | | |  | | | | | | | | | | 医生意见  签 字 |
| 右 | | | |
| 鼻 | 嗅 觉 |  | | | | 鼻 及 鼻  窦 疾 病 | | |  | | | | | | | | | |
| 咽 喉 |  |  | | | | 唇 腭 | | |  | | | | | | | | | |
| 齿 | 龋 齿 |  | | | | 缺 齿 | | |  | | | | 牙周病 | | | |  | | 医生意见  签 字 |
| 其 它 |  | | | | | | | | | | | | | | | | | |
| 外  科 | 身 长 | 公分 | | | 胸 围 | | | | 公分 | | | | | 皮 肤 | |  | | | | 医生意见  签 字 |
| 体 重 | 公斤 | | | 呼 吸 差 | | | | 公分 | | | | |
| 淋 巴 |  | | | 甲 状 腺 | | | |  | | | | | 脊 柱 | |  | | | |
| 四 肢 |  | | | 关 节 | | | |  | | | | | 扁平足 | |  | | | |
| 泌 尿  生殖器 |  | | | | | | | | | | | | 肛 门 | |  | | | |
| 疝 |  | | | | | | | | | 其 它 | | |  | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 内  科 | 血 压 | 毫米水银柱 | | | | | | 医生意见  签 字 |
| 发 育 及  营养状况 |  | | | | | |
| 神经及精神 |  | | | 口吃 |  | |
| 肺及呼吸道 |  | | | | | |
| 心脏及血管 |  | | | | | |
| 腹部器官 |  | 肝 |  | | | |
| 脾 |  | | | |
| 其 它 |  | | | | | |
| 化验检查 | | 化验员签字 | | | | | | |
| 胸部爱克  期线透视 | | 医生签字 | | | | | | |
| 其它检查 | |  | | | | | | |
| 检查结果 | | 检验组长 | | | | | 签名 | |
| 负责医生 | | | | |
| 年 月 日 | | | | | | |
| 审查单位  意 见 | | 审查单位签名 | | | | | | |
| 备 考 | |  | | | | | | |