

腺 婢 撐 耽 饑 販 駢 瘰

FOREIGNER PHYSICAL EXAMINATION FORM

掩留 Name		恹艰 Sex	<input type="checkbox"/> 嗜 Male <input type="checkbox"/> 胸 Female	挤磁蛭躅 Date of birth		三借 Photo																												
勤柿荔筐噬寿 Present mailing address																																		
婢懸 Nationality		挤磁噬 Birth Place		痼似 Blood type																														
苻立罌炉涑躅币英函圖ㄨ揚錫刘邵箴烧恹“炉”璋“罌”ㄣ Have you ever had any of the following disease? ㄨEach item must be answered “Yes” or “No”ㄣ																																		
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">痲圓囟抓 Typhus fever</td> <td style="width: 10%; text-align: center;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td style="width: 33%;">涑坎 Bacillary dysentery</td> <td style="width: 10%; text-align: center;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>租焊鵲坎圖 Poliomyelitis</td> <td style="text-align: center;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>葑獄尾涑 Brucellosis</td> <td style="text-align: center;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>壇砒 Diphtheria</td> <td style="text-align: center;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>圖瘵恹櫛 Viral hepatitis</td> <td style="text-align: center;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>滄啼：Scarlet fever</td> <td style="text-align: center;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>巢踰躅凶鄂涑 Puerperal streptococcus infection</td> <td style="text-align: center;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>烧嘍：Relapsing fever</td> <td style="text-align: center;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td></td> <td style="text-align: center;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>囟抓梅轿囟抓 Typhoid and paratyphoid fever</td> <td style="text-align: center;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td></td> <td></td> </tr> <tr> <td>曉瘍恹橫梗靛櫛 Epidemic cerebrospinal meningitis</td> <td style="text-align: center;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td></td> <td></td> </tr> </table>							痲圓囟抓 Typhus fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	涑坎 Bacillary dysentery	<input type="checkbox"/> No <input type="checkbox"/> Yes	租焊鵲坎圖 Poliomyelitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	葑獄尾涑 Brucellosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	壇砒 Diphtheria	<input type="checkbox"/> No <input type="checkbox"/> Yes	圖瘵恹櫛 Viral hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	滄啼：Scarlet fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	巢踰躅凶鄂涑 Puerperal streptococcus infection	<input type="checkbox"/> No <input type="checkbox"/> Yes	烧嘍：Relapsing fever	<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	囟抓梅轿囟抓 Typhoid and paratyphoid fever	<input type="checkbox"/> No <input type="checkbox"/> Yes			曉瘍恹橫梗靛櫛 Epidemic cerebrospinal meningitis	<input type="checkbox"/> No <input type="checkbox"/> Yes		
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罌炉涑躅币英蓝帘哄宏嶼拚梅趾橫堦圖圖ㄨ揚錫刘邵箴烧恹“炉”璋“罌”ㄣ Do you have any of the following disease or disorders endangering the public order and security? ㄨEach item must be answered “Yes” or “No”ㄣ																																		
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腕鞣 Height	叁杓 cm	耽吧 Weight	哄糅 Kg	痼佬 Blood pressure	蔭杓擊 mmHg																													
粮樞渥恍 Development		潭呼儻恍 Nourishment		錠莖 Neck																														
砵晋 黄 L Vision 邻 R		媵葦砵晋 Corrected vision	黄 L 邻 R	虹 Eyes																														
茈汶晋 Color sense		嫡標 Skin		雙蒼際 Lymph nodes																														
橄 Ears		廔 Nose		枸場耽 Tonsils																														
犸 Heart		楮 Lungs		襖莖 Abdomen																														
梗 Spine		梢糕 Extremities		坎噉捌瞭 Nervous system																														

猴翅矜谿

Other abnormal findings