

FOREIGNER PHYSICAL EXAMINATION FORM

Name		Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthday		(Photo (Stamped Official Stamp))														
Present mailing address																				
Nationality (or Area)		Birth place		Blood type																
<p>“ ” “ ”</p> <p>Have you ever had any of the following diseases? (Each item must be answered “Yes” or “No”)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Typhus fever <input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td style="width: 50%;">Bacillary dysentery <input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>Poliomyelitis <input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>Brucellosis <input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>Diphtheria <input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>Viral hepatitis <input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>Scarlet fever <input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td>Puerperal streptococcus infection <input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>Relapsing fever <input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td></td> </tr> <tr> <td style="text-align: center;">Typhoid and paratyphoid fever <input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td></td> </tr> <tr> <td style="text-align: center;">Epidemic cerebrospinal meningitis <input type="checkbox"/>No <input type="checkbox"/>Yes</td> <td></td> </tr> </table>							Typhus fever <input type="checkbox"/> No <input type="checkbox"/> Yes	Bacillary dysentery <input type="checkbox"/> No <input type="checkbox"/> Yes	Poliomyelitis <input type="checkbox"/> No <input type="checkbox"/> Yes	Brucellosis <input type="checkbox"/> No <input type="checkbox"/> Yes	Diphtheria <input type="checkbox"/> No <input type="checkbox"/> Yes	Viral hepatitis <input type="checkbox"/> No <input type="checkbox"/> Yes	Scarlet fever <input type="checkbox"/> No <input type="checkbox"/> Yes	Puerperal streptococcus infection <input type="checkbox"/> No <input type="checkbox"/> Yes	Relapsing fever <input type="checkbox"/> No <input type="checkbox"/> Yes		Typhoid and paratyphoid fever <input type="checkbox"/> No <input type="checkbox"/> Yes		Epidemic cerebrospinal meningitis <input type="checkbox"/> No <input type="checkbox"/> Yes	
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<p>(“ ” “ ”)</p> <p>Do you have any of the following diseases or disorders endangering the public order and security? (Each item must be answered “Yes” or “No”)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 80%;">Toxicomania.....</td> <td style="width: 20%;"><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>Mental confusion.....</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td>Psychosis: Manic psychosis.....</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td> Paranoid psychosis.....</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> <tr> <td> Hallucinatory.....</td> <td><input type="checkbox"/>No <input type="checkbox"/>Yes</td> </tr> </table>							Toxicomania.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	Mental confusion.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	Psychosis: Manic psychosis.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	Paranoid psychosis.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hallucinatory.....	<input type="checkbox"/> No <input type="checkbox"/> Yes				
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Height	CM	Weight	Kg	Blood pressure	mmHg															
Development		Nourishment		Neck																
Vision	L _____ R _____	Corrected vision	L _____ R _____	Eyes																
Colour sense		Skin	Lymph nodes																	

Spine		Extremities		Nervous system									
Other abnormal findings													
<p style="text-align: center;">X</p> <p style="text-align: center;">()</p> <p style="text-align: center;">Chest X-ray exam (attached chest X-ray report)</p>		ECC											
<p style="text-align: center;">()</p> <p style="text-align: center;">Laboratory exam (attached test report of AIDS, Syphilis etc)</p>													
<p style="text-align: center;">:</p> <p style="text-align: center;">None of the following diseases of disorders found during the present examination.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Cholera</td> <td style="width: 50%;">Venereal Disease</td> </tr> <tr> <td>Yellow fever</td> <td>Lung tuberculosis</td> </tr> <tr> <td>Plague</td> <td>AIDS</td> </tr> <tr> <td>Leprosy</td> <td>Psychosis</td> </tr> </table>						Cholera	Venereal Disease	Yellow fever	Lung tuberculosis	Plague	AIDS	Leprosy	Psychosis
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<p>Suggestion</p> <p>Signature of physician</p>			<p style="text-align: center;">Official Stamp</p> <p style="text-align: center;">Date</p>										