FOREIGNER PHYSICAL EXAMINATION FORM

Name		Sex	☐ Male ☐ Female	Birthday		Photo (Stamped Official Stamp)
Present mailing address						
Nationality (or Area)		Birth place		Blood Type		

Have you ever had any of the following diseases?
(Each item must be answered "Yes" or "No")

Typhus fever	☐No ☐Yes	Bacillary dysentery	☐No ☐Yes
Poliomyelitis	☐No ☐Yes	Brucellosis	☐No ☐Yes
Diphtheria	☐No ☐Yes	Viral hepatitis	☐No ☐Yes
Scarlet fever	☐No ☐Yes	Puerperal streptococcus infection	☐No ☐Yes
Relapsing fever	☐No ☐Yes		

Typhoid and paratyphoid fever ☐No ☐Yes

Epidemic cerebrospinal meningitis ☐No ☐Yes

Do you have any of the following diseases or disorders endangering the public order and security?
(Each item must be answered "Yes" or "No")

Toxicomania……☐No ☐Yes

Mental confusion……☐No ☐Yes

Psychosis：

Manic paychosis……☐No ☐Yes

Paranoid psychosis……☐No ☐Yes

Hallucinatory……☐No ☐Yes

Height	CM	Weight		Kg	Blood pressure	mmHg
Development		Nourishment		Neck		
Vision L R		Corrected vision L R		Eyes		
Colour sense		Skin		Lymph nodes		
Ears		Nose		Tonsils		
Heart		Lungs		Abdomen		

Spine		Extremities		Nervous system	

Other abnormal findings

Chest X-ray exam (attached chest X-ray report)	ECC	

Laboratory exam (attached test report of AIDS, Syphilis etc)

None of the following diseases of disorders found during the present examination.

Cholera	Venereal Disease
Yellow fever	Lung tuberculosis
Plague	AIDS
Leprosy	Psychosis

Suggestion

Official Stamp

Signature of physician

Date