长春市教师资格认定体检专用表

第 号

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓名 | |  | | 性别 |  | | 出 生  年 月 | |  | | | | 民族 |  | 职业 | |  | 一寸  正面  免冠  彩色  照片 |
| 单位 | |  | | | | | 现住所 | |  | | | | | | | | |
| 既往病史 | | | |  | | | | | | | | | | | | | |
| 以上所列各项由申请人本人填写 | | | | | | | | | | | | | | | | | | |
| 外  科 | 身 高 | | 厘米 | | | 体重 | | 公斤 | | | | 胸 围 | | | | 厘米 | | |
| 淋 巴 | |  | | | | | | | | | 皮 肤 | | | |  | | |
| 脊 柱 | |  | | | | | | | | | 四 肢 | | | |  | | |
| 甲状腺 | |  | | | | | | | | | 泌 尿  生殖器 | | | |  | | |
| 其 他 | |  | | | | | | | | | | | | | | | |
| 医 生  意 见 | | 签字： | | | | | | | | | | | | | | | |
| 内  科 | 血 压 | | 毫米汞柱 | | | | | | | | 脉 搏 | | | 每分钟 | | | | |
| 心脏血管系统 | |  | | | | | | | | 肺 呼  吸 道 | | |  | | | | |
| 精神及神 经 | |  | | | | | | | | 腹 腔  脏 器 | | |  | | | | |
| 其 他 | |  | | | | | | | | | | | | | | | |
| 医 生  意 见 | | 签字： | | | | | | | | | | | | | | | |
| 胸部透视  医生签字： | | | | | | | | | | 心电  医生签字： | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 五  官  科 | 眼 | 视力 | 右 |  | | 矫正  视力 | 右 | |  | | 眼  疾 | 右 | |  | 色觉 |  |
| 左 |  | | 左 | |  | | 左 | |  |
| 耳 | 听力 | 右 | 公尺 | | | | | 耳疾 | | | |  | | | |
| 左 | 公尺 | | | | |
| 鼻 | 嗅觉 |  | | | | | 鼻疾 |  | | | | | | | |
| 咽喉 | |  | | | | | 口吃 |  | | | | | 其他 |  | |
| 医生  意见 | | 签字： | | | | | | | | | | | | | |
| B超 | | 医生签字： | | | | | | | | | | | | | | |
| 化  验  检  查 | | 丙氨酸氨基转移酶(ALT) | | | 医生签字： | | | | | | | | | | | |
| 血常规 | | | 医生签字： | | | | | | | | | | | |
| 尿常规 | | | 医生签字： | | | | | | | | | | | |
| 主检医师结论  签名：  年 月 日 | | | | | | | | | | 体检医疗单位意见  （盖章）  年 月 日 | | | | | | |
| 复审结论  签名：  年 月 日 | | | | | | | | | | | | | | | | |

注：此表须正反面打印