黑龙江省申请教师资格人员体检表

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓名 | |  |  |  | 年 龄 |  | 性别 |  |  |  | 婚否 | |  |  | 民族 | |  | 插入照片  （彩色打印） |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 籍贯 | |  |  |  | 现住所 |  |  |  |  |  | 联系电话 | |  |  |  |  |  |
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| 既 往 病 史 | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  | 本人签字： | | | | | |
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|  |  |  |  |  |  |  | 以上栏目由申请人填写 | | | | | | | |  |  |  |  |
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|  |  |  |  |  | 右 | | 矫正 | |  | 右 |  |  | 矫正 | |  | 右 | | 医师意见 |
|  |  | 裸 眼 视 力 | | |  |  |  |  |  |  |  |  |  |
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|  |  |  |  | 视力 | |  |  |  |  | 度数 | |  |  |  |  |
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|  |  | 辨 色 力 | | |  |  |  |  |  |  | 眼病 | |  | |  |  |  |  |
| 五 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 签名 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 听 | | 力 | 左耳 | |  |  | 米 | |  | 右耳 | | |  |  | 米 | 医师意见 |
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| 官 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 签名 |
|  | 耳 | | 疾 |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  | 鼻 |  | 嗅 觉 | |  |  |  | 鼻及鼻窦 | | |  | |  |  |  | 医师意见 |
| 科 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 面 | | 部 |  |  |  |  |  | 咽 |  | 喉 |  |  |  |  |  |  |
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|  |  | 口 腔 唇 腭 | | |  |  |  |  |  |  | 齿 | |  |  |  |  |  |
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|  |  | 其 | | 他 |  |  |  |  |  |  |  |  |  |  |  |  |  | 医师签名 |
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|  |  | 身 | | 高 |  |  | 公分 | |  | 体 |  | 重 |  | |  |  | 公斤 | 医师意见 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |
| 外 |  | 淋 | | 巴 |  |  |  |  |  | 脊 |  | 柱 |  |  |  |  |  |  |
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|  |  | 四 | | 肢 |  |  |  |  |  | 关 |  | 节 |  |  |  |  |  |  |
| 科 |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |
|  | 皮 | | 肤 |  |  |  |  |  | 颈 |  | 部 |  |  |  |  |  |  |
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|  | 血 | | 压 |  |  |  |  |  |  |  |  |  | 医师意见 | |
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|  | 心脏及血管 | | |  |  |  |  |  |  |  |  |  |  |  |
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| 内 | 呼 吸 系 统 | | |  |  |  |  |  |  |  |  |  |  |  |
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|  | 腹 部 器 官 | | |  | 肝 | |  | 脾 |  |  | 其 他 |  |  |  |
| 科 | （ B | | 超 ） |  |  |  |  |  |  |  |  |  |  |  |
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|  | 神 经 及 精 神 | | |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  | 签名 |  |
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|  | 其 | | 他 |  |  |  |  |  |  |  |  |  |  |  |
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| 妇科检查 | |  |  |  |  |  |  |  |  |  |  |  | 医师签名 | |
|  | |  |  |  |  |  |  |  |  |  |  |  |  | |
| 胸部透视 | |  |  |  |  |  |  |  |  |  |  |  | 医师签名 | |
|  | |  |  | |  |  |  | |  |  |  |  |  | |
| 化验检查 | |  | 肝功 | |  |  | 血糖 | |  |  | 其 他 |  | 医师签名 | |
| （附化验单） | |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 体检结论 | |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  | 负责医师签字: | | |  |  |  |
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| 体检医院 | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 意 | 见 |  |  |  |  |  |  |  | 体检医院公章 | | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  | 年 | 月 | | 日 |
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说明： 1.即往病史指心脏病、肝炎、哮喘、精神病、癫痫、结核、皮肤病、性传播性疾病等病史。

本人应如实填写患病时间、治愈等情况，否则后果自负。

2．参加体检者，检查当日须空腹。

3.对出现呼吸系统疑似症状者增加胸片检查项目。