附件2

宁夏回族自治区教师资格认定申请人体检表(2021年)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓名 |  | | | 性别 |  | | 年龄 | | | |  | | | | 民族 | | | |  | 婚否 | | |  | 照片 |
| 身份证号码 | |  | | | | | | | | | 网报名号 | | | | | | | |  | | | | |
| 申请教师资格种类、学科 | |  | | | | | | | | | 手机号码 | | | | | | | |  | | | | |
| **请申请人本人如实填写下列项目：**  （在每项后的空格中打“√”回答“有”或“无”。如故意隐瞒，后果自负。) | | | | | | | | | | | | | | | | | | | | | | | | |
| 病名 | | | | 有 | 无 | | 治愈时间 | | | | | | 病名 | | | | | | | 有 | | | 无 | 治愈时间 |
| 严重胃肠疾病 | | | |  |  | |  | | | | | | 恶性肿瘤 | | | | | | |  | | |  |  |
| 癫痫 | | | |  |  | |  | | | | | | 精神病 | | | | | | |  | | |  |  |
| 神经官能症（癔症） | | | |  |  | |  | | | | | | 晚期血吸虫病 | | | | | | |  | | |  |  |
| 类风湿性关节炎 | | | |  |  | |  | | | | | | 红斑狼疮 | | | | | | |  | | |  |  |
| 冠心病 | | | |  |  | |  | | | | | | 结核病 | | | | | | |  | | |  |  |
| 风心病 | | | |  |  | |  | | | | | | 糖尿病 | | | | | | |  | | |  |  |
| 先心病 | | | |  |  | |  | | | | | | 肝硬化 | | | | | | |  | | |  |  |
| 心肌病 | | | |  |  | |  | | | | | | 急慢性肝炎 | | | | | | |  | | |  |  |
| 甲亢 | | | |  |  | |  | | | | | | 急慢性肾炎 | | | | | | |  | | |  |  |
| 支气管扩张 | | | |  |  | |  | | | | | | 肾功能不全 | | | | | | |  | | |  |  |
| 支气管哮喘 | | | |  |  | |  | | | | | | 严重外伤史 | | | | | | |  | | |  |  |
| 肺气肿 | | | |  |  | |  | | | | | | 胰腺疾病 | | | | | | |  | | |  |  |
| 结缔组织病 | | | |  |  | |  | | | | | | 性传播疾病 | | | | | | |  | | |  |  |
| 皮肤病 | | | |  |  | |  | | | | | | 其他 | | | | | | |  | | |  |  |
| 备注： | | | | | | | | | | | | | | | | | | | | | | | | |
| **受检者确认签名：**  年 月 日 | | | | | | | | | | | | | | | | | | | | | | | | |
| 身高 | 厘米 | | | | | 体重 | | | 公斤 | | | | | | | | 血压 | | | | | / mmHg | | |
| **内科** | 心脏及血管 | | |  | | | | | | 呼吸系统 | | | | | | |  | | | | | | | 医生意见：  签名： |
| 腹部器官 | | |  | | | | | | 神经内科 | | | | | | |  | | | | | | |
| 其他 | | |  | | | | | | | | | | | | | | | | | | | |
| **外科** | 淋巴 | | |  | | | | | | 脊柱 | | | | | | |  | | | | | | | 医生意见：  签名： |
| 四肢 | | |  | | | | | | 关节 | | | | | | |  | | | | | | |
| 皮肤 | | |  | | | | | | 颈部 | | | | | | |  | | | | | | |
| 其他 | | |  | | | | | | | | | | | | | | | | | | | |
| **眼科** | 裸眼  视力 | | | 右 | |  | | | | | | 矫正视力 | | | | 右 | | | |  | | | | 医生意见：  签名： |
| 左 | |  | | | | | | 左 | | | |  | | | |
| 辨色力 | | |  | | | | | | | | 眼病 | | | |  | | | | | | | |
| 其他 | | |  | | | | | | | | | | | | | | | | | | | |
| **五**  **官**  **科** | 听力 | | | 左耳： 米 | | | | | | | | | | 右耳： 米 | | | | | | | | | | 医生意见：  签名： |
| 耳疾 | | |  | | | | | | | | | | | | | | | | | | | |
| 鼻部 | | | 嗅觉 | |  | | | | | | 鼻及鼻窦 | | | | | |  | | | | | |
| 咽喉 | | |  | | | | | | | | 口腔唇颚 | | | | | |  | | | | | |
| 齿 | | |  | | | | | | | | 面部 | | | | | |  | | | | | |
| 其他 | | |  | | | | | | | | | | | | | | | | | | | |
| **检验**  **项目** | 血常规 | | |  | | | | | | | | | | | | | | | | | 医生意见：  签 名： | | | |
| 生化类 | | | 肝功能 | | | | | | | | | | | | | | | | | | | | 医生意见：  签名： |
| 肾功能 | | | | | | | | | | | | | | | | | | | |
| 葡萄糖 | | | | | | | | | | | | | | | | | | | |
| 免疫类 | | | 艾滋病病毒抗体（HIV） | | | | | | | | | | | | | | | | | | | | 医生意见：  签名： |
| 梅毒血清特异性抗体（TPHA） | | | | | | | | | | | | | | | | | | | |
| 尿常规 | | |  | | | | | | | | | | | | | | | | | | | | 医生意见：  签名： |
| **幼儿园教师资格申请人体检增加项目** | | | 滴虫 | | | | | 念球菌 | | | | | | | | | | 淋球菌 | | | | | | 医生意见：  签名： |
|  | | | | |  | | | | | | | | | |  | | | | | |
| **心电图** | | |  | | | | | | | | | | | | | | | | | | | | | 医生意见：  签名： |
| **放射科** | | |  | | | | | | | | | | | | | | | | | | | | | 医生意见：  签名： |
| **B超检查** | | |  | | | | | | | | | | | | | | | | | | | | | 医生意见：  签名： |
| **体检结论** | | | 负责医师签名： | | | | | | | | | | | | | | | | | | | | | |
| **体检医院**  **意见** | | | 体检负责人签名： 医院公章或体检专用章  年 月 日 | | | | | | | | | | | | | | | | | | | | | |