附件1

山西省申请认定中小学教师资格人员体检表

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓名 | | |  | | 年 龄 | |  | | | 性别 |  | | | 婚否 | | | |  | 民族 | |  | | 相  片 |
| 籍贯 | | |  | | 现住所 | |  | | | | | | | 联系电话 | | | |  | | | | |
| 身份证号码 | | | | |  | | | | | | | | | | | | | | | | | |
| 既 往 病 史 | | | | | 本人签字： | | | | | | | | | | | | | | | | | |
| **以上栏目由申请人填写** | | | | | | | | | | | | | | | | | | | | | | | |
| 五  官  科 | | 裸眼视力 | | | 右 | | | | | 矫正  视力 | | 右 | | | | | 矫正  度数 | | | 右 | | | 医师意见  签名 |
| 左 | | | | | 左 | | | | | 左 | | |
| 辨 色 力 | | |  | | | | | | | 眼病 | | | | |  | | | | | |
| 听 力 | | | 左耳 米 | | | | | | | | | | 右耳 米 | | | | | | | | 医师意见  签名 |
| 耳 疾 | | |  | | | | | | | | | | | | | | | | | |
| 鼻 | | | 嗅觉 | | |  | | | | 鼻及鼻窦 | | | | |  | | | | | | 医师意见  签名 |
| 面 部 | | |  | | | | | | | 咽喉 | | | | |  | | | | | |
| 口腔唇腭 | | |  | | | | | | | 齿 | | | | |  | | | | | |
| 其 他 | | |  | | | | | | | | | | | | | | | | | | 医师签名 |
| 外  科 | | 身 高 | | | 公分 | | | | | | | | 体 重 | | | | 公斤 | | | | | | 医师意见  签名 |
| 淋 巴 | | |  | | | | | | | | 脊 柱 | | | |  | | | | | |
| 四 肢 | | |  | | | | | | | | 关 节 | | | |  | | | | | |
| 皮 肤 | | |  | | | | | | | | 颈 部 | | | |  | | | | | |
| 其 他 | | |  | | | | | | | | | | | | | | | | | |
| 内  科 | | 血 压 | | |  | | | | | | | | | | | | | | | | 医师意见  签名 | |
| 心脏及血管管 | | |  | | | | | | | | | | | | | | | |
| 呼吸系统 | | |  | | | | | | | | | | | | | | | |
| 腹部器官  （B超） | | | 肝 | | | | | 脾 | | | | | | 其 他 | | | | |
|  | | | | |  | | | | | |  | | | | |
| 神经及精神 | | |  | | | | | | | | | | | | | | | |
| 其他 | | |  | | | | | | | | | | | | | | | |
| 妇科检查 | | |  | | | | | | | | | | | | | | | | | | 医师签名 | |
| 胸部透视 | | |  | | | | | | | | | | | | | | | | | | 医师签名 | |
| 化验检查  （附化验单） | | | 肝功 | | | | | 血糖 | | | | | | | 其 他 | | | | | | 医师签名 | |
|  | | | | |  | | | | | | |  | | | | | |
| 体检结论 | | | 负责医师签字: | | | | | | | | | | | | | | | | | | | |
| 体检医院  意 见 | | | 体检医院公章  年 月 日 | | | | | | | | | | | | | | | | | | | |

说明： 1.既往病史指心脏病、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。