福建省教师资格申请人员

体

检

表

|  |  |
| --- | --- |
| 福 建 省 教 育 厅 | 制 |
| 福建省卫生与计划生育委员会 |

体检须知

为了准确反映受检者身体的真实状况，请注意以下事项：

1.均应到指定医院进行体检，其它医疗单位的检查结果一律无效。

2.严禁弄虚作假、冒名顶替；如隐瞒病史影响体检结果的，后果自负。

3.体检表上贴近期二寸免冠照片一张。

4.本表第二页由受检者本人填写（用黑色签字笔或钢笔），要求字迹清楚，无涂改，病史部分要如实、逐项填齐，不能遗漏。

5.体检前一天请注意休息，勿熬夜，不要饮酒，避免剧烈运动。

6.体检当天需进行采血、B超等检查，请在受检前禁食8-12小时。

7.女性受检者月经期间请勿做妇科及尿液检查，待经期完毕后再补检；怀孕或可能已受孕者，事先告知医护人员，勿做X光检查。

8.请配合医生认真检查所有项目，勿漏检。若自动放弃某一检查项目，将会影响对您的录用。

9.体检医师可根据实际需要，增加必要的相应检查、检验项目。

10.如对体检结果有疑义，请按有关规定办理。

|  |  |
| --- | --- |
| **腹**  **部**  **B**  **超**  **检**  **查** | **建议： 医师签字：** |
| **体**  **检**  **结**  **论**  **及**  **建**  **议** | **根据《福建省教师资格申请人员体检标准》，体检结论属于：** |
| **体检医院签章处**    **主检医师签字： 年 月 日** |

**注：**对于滴虫和念球菌两项妇科检查项目未婚女性采取阴道口取样。

|  |  |
| --- | --- |
| **心**  **电**  **图** | **建议： 医师签字：** |
| **胸**  **部**  **X**  **光**  **片** | **建议： 医师签字：** |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **姓名** |  | | **性 别** | |  | **出生年月** | |  | |  | |
| **民族** |  | | **婚姻状况** | |  | **籍 贯** | |  | |
| **联系电话** |  | | **通讯地址** | |  | | | | |
| **申请资格**  **种类** |  | | **身份证号** | |  | | | | |
| **请本人如实详细填写下列项目**  **（在每一项后的空格中打“√”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** |
| **高血压病** | |  |  |  | | **糖尿病** |  | |  | |  |
| **冠心病** | |  |  |  | | **甲亢** |  | |  | |  |
| **风心病** | |  |  |  | | **贫血** |  | |  | |  |
| **先心病** | |  |  |  | | **癫痫** |  | |  | |  |
| **心肌病** | |  |  |  | | **精神病** |  | |  | |  |
| **支气管扩张** | |  |  |  | | **神经官能症** |  | |  | |  |
| **支气管哮喘** | |  |  |  | | **吸毒史** |  | |  | |  |
| **肺气肿** | |  |  |  | | **急慢性肝炎** |  | |  | |  |
| **消化性溃疡** | |  |  |  | | **结核病** |  | |  | |  |
| **肝硬化** | |  |  |  | | **性传播疾病** |  | |  | |  |
| **胰腺疾病** | |  |  |  | | **恶性肿瘤** |  | |  | |  |
| **急慢性肾炎** | |  |  |  | | **手术史** |  | |  | |  |
| **肾功能不全** | |  |  |  | | **严重外伤史** |  | |  | |  |
| **结缔组织病** | |  |  |  | | **其他** |  | |  | |  |
| **备 注：** | |  | | | | | | | | | |
| **受检者签字：**    **体检日期： 年 月 日** | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **身高** | | **厘米** | | | | | **体重** | | **公斤** | | | | **血压** | | | **/ mmHg** | | | |
| **内**  **科** | | **病史：曾患过何种疾病（起病时间及目前症状）。** | | | | | | | | | | | | | | | | | |
| **心脏** | | | | **心界**  **杂音** | | | | | **心率 次/分 律** | | | | | | | | |
| **肺** | | | |  | | | | | **腹部** | | | |  | | | | |
| **肝** | | | |  | | | | | **神经系统** | | | |  | | | | |
| **脾** | | | |  | | | | | **其他** | | | |  | | | | |
| **建议** | | | |  | | | | | | | | | **医师签字** | | | |  |
| **外**  **科** | | **病史：曾做过何种手术或有无外伤史（名称及时间），目前功能如何。** | | | | | | | | | | | | | | | | | |
| **皮肤** | | | |  | | | | | **浅表**  **淋巴结** | | | |  | | | | |
| **头颅** | | | |  | | | | | **甲状腺** | | | |  | | | | |
| **乳腺** | | | |  | | | | | **脊柱**  **四肢关节** | | | |  | | | | |
| **肛门**  **外生殖器** | | | |  | | | | | **其他** | | | |  | | | | |
| **建议** | | | |  | | | | | | | | | **医师签字** | | | |  |
| **眼**  **科** | | **裸眼**  **视力** | | | | **右** | | | **矫正**  **视力** | **右** | | | | | **医师签字** | | | |  |
| **左** | | | **左** | | | | |
| **色觉** | | | |  | | | | | | | | | | | | | |
| **其他** | | | |  | | | | | | | | | | | | | |
| **建议** | | | |  | | | | | | | | | **医师签字** | | | |  |
| **耳**  **鼻**  **喉**  **科** | | **听力** | | **左耳**  **右耳** | | | | | | | **耳部** | | | | |  | | | |
| **鼻部** | |  | | | | | | | **咽部** | | | | |  | | | |
| **喉部** | |  | | | | | | | **嗅觉** | | | | |  | | | |
| **其他** | |  | | | | | | | | | | | | | | | |
| **建议** | |  | | | | | | | | | **医师签字** | | | |  | | |
| **口**  **腔**  **科** | | **唇腭舌** | |  | | | | | | | **牙齿** | | | | |  | | | |
| **是否**  **口吃** | |  | | | | | | | **发音是否**  **嘶哑** | | | | |  | | | |
| **其他** | |  | | | | | | | | | | | | | | | |
| **建议** | |  | | | | | | | | | **医师签字** | | | |  | | |
| **妇科检查** | |  | | | | | | | | | | | **医师签字** | | | |  | | |
| **申请幼儿教师资格**  **加测** | | **淋球菌** | | | | |  | | | | | | **医师签字** | | | |  | | |
| **梅毒螺旋体** | | | | |  | | | | | |
| **妇科** | **滴虫** | | | |  | | | | | |
| **念球菌** | | | |  | | | | | |