江苏省幼儿园教师资格申请人员体检表

体检号

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **姓 名** |  | | | | **年 龄** | | |  | | | | | **性 别** | | | | |  | | **照**  **片** |
| **民 族** |  | | | | **籍 贯** | | |  | | | | | **婚 否** | | | | |  | |
| **现住所** |  | | | | | | | | | | | | **联 系**  **电 话** | | | | |  | |
| **既 往 病 史**  **（本人如实填写）** | | | | | 1.肝炎 2.结核 3.皮肤病 4.性传播性疾病  5.精神病 6.其他（请注明）  受检者确认签字： | | | | | | | | | | | | | | | |
| **五 官 科** | 裸 眼  视 力 | | 左 | | | | 矫 正  视 力 | | | | 左 | | | 矫 正  度 数 | | | | | 左 | 医师意见  和签名  眼科  耳鼻喉科  口腔科 |
| 右 | | | | 右 | | | 右 |
| 辨色力 | |  | | | | | | | | 眼病 | | |  | | | | | |
| 听 力 | | 左耳 米 | | | | | | 右耳 米 | | | | | | | 其他 | | |  |
| 鼻 | | 嗅觉 | | |  | | | | | 鼻及鼻窦 | | | | |  | | | |
| 面 部 | |  | | | | | | | | 咽 喉 | | |  | | | | | |
| 口腔唇腭 | |  | | | | | | | | 齿 | | |  | | | | | |
| 其 他 | |  | | | | | | | | | | | | | | | | |
| **内 科** | 血 压 | | | | 毫米汞柱 | | | | | | | 心 率 | | | | 次/分钟 | | | | 医师意见  签名 |
| 神经及精神 | | | |  | | | | | | | | | | | | | | |
| 发育及营养状况 | | | |  | | | | | | | | | | | | | | |
| 肺及呼吸道 | | | |  | | | | | | | | | | | | | | |
| 心脏及心血管 | | | |  | | | | | | | | | | | | | | |
| 腹部器官 | | | | 肝 | | | |  | | | | | | | | | | |
| 脾 | | | |  | | | | | | | | | | |
| 其 他 | | | |  | | | | | | | | | | | | | | |
| **外 科** | 身 高 | | | 厘米 | | | | | | 体 重 | | | | | 千克 | | | | | 医师意见  签名 |
| 淋 巴 | | |  | | | | | | 脊 柱 | | | | |  | | | | |
| 四 肢 | | |  | | | | | | 关 节 | | | | |  | | | | |
| 皮 肤 | | |  | | | | | | 颈 部 | | | | |  | | | | |
| 其 他 | | |  | | | | | | | | | | | | | | | |
| **胸部透视**  **（胸片）** | | （注：对出现呼吸系统疑似症状者须进行胸片项目检查） | | | | | | | | | | | | | | | | | | 医师签名 |
| **化验检查** | | 淋球菌 | | | |  | | | | | 梅毒螺旋体 | | | | | |  | | | 医师签名 |
| ALT | | | |  | | | | | 其他项目 | | | | | |  | | |
| **妇科检查** | | 滴 虫 | | | | | | | | |  | | | | | | | | | 医师签名 |
| 外阴阴道假丝酵母菌  （念珠菌） | | | | | | | | |  | | | | | | | | |
| **体检结论** | | 负责医师签名：  年 月 日 | | | | | | | | | | | | | | | | | | |
| **体检医院**  **意 见** | | （体检医院盖章）  年 月 日 | | | | | | | | | | | | | | | | | | |
| **备 注** | |  | | | | | | | | | | | | | | | | | | |