附件3：

山南市2022年在职教师“公开遴选”

体 检 表

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **姓 名** |  | | | | **性别** | |  | | **年龄** | | |  | | | **民族** | |  | **贴**  **相**  **片**  **处** |
| **籍 贯** |  | | | | **身份证**  **号码** | | | |  | | | | | | | | |
| **工 作**  **单 位** |  | | | | | | | | **职业** | | | |  | | | | |
| **通 讯**  **地 址** |  | | | | | | | | **联系电话** | | | |  | | | | |
| **既往**  **病史** | **传染病** | | | | |  | | | | | | | | | | | | |
| **心理及精神**  **病史** | | | | |  | | | | | | | | | | | | |
| **其他** | | | | |  | | | | | | | | | | | | |
| **（以上空白处由申请人如实填写）** | | | | | | | | | | | | | | | | | | |
| **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** | | | | | | | |
| **鼻** | **嗅觉** | | |  | | | | | **鼻及**  **鼻窦** | | | | |  | | |
| **面部** |  | | | | | | **咽喉** | | | | | |  | | | |
| **口腔唇腭** |  | | | | | | **齿** | | | | | |  | | | |
| **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** | |  | | | | | | | | | | | | | | |
| **内**  **科** | **血压** | |  | | | | | | | | | | | | | | | **医师意见：**  **签名：** |
| **营养状况** | |  | | | | | | | | | | | | | | |
| **心脏及血管** | |  | | | | | | | | | | | | | | |
| **呼吸系统** | |  | | | | | | | | | | | | | | |
| **神经系统** | |  | | | | | | | | | | | | | | |
| **腹部器官** | | **肝** |  | | | | | | | | | | | | | |
| **脾** |  | | | | | | | | | | | | | |
| **其他** | |  | | | | | | | | | | | | | | |
| **化验检查**  **（附化验单据）** | | | **血常规** | |  | | | | **肝功能** | |  | | | | | **尿常规** | |  |
| **心**  **电**  **图** | **医师签名：** | | | | | | | | | | | | | | | | | |
| **胸部透视** | **医师签名：** | | | | | | | | | | | | | | | | | |
| **体检结论** | **主检医生签名：**  **年 月 日** | | | | | | | | | | | | | | | | | |
| **体检医院意见** | **体检医院 盖章**    **年 月 日** | | | | | | | | | | | | | | | | | |