FOREIGNER PHYSICAL EXAMINATION FORM

Name		Sex	□ Male □ Female	Birthday		( )
Present mailing address						Photo (Stamped Official Stamp)
Nationality (or Area)		Birth place		Blood type		

Have you ever had any of the following diseases?
(Each item must be answered "Yes" or "No")

Typhus fever □No □Yes
Poliomyelitis □No □Yes
Diphtheria □No □Yes
Scarlet fever □No □Yes
Relapsing fever □No □Yes
Bacillary dysentery □No □Yes
Brucellosis □No □Yes
Viral hepatitis □No □Yes
Puerperal streptococcus infection □No □Yes
Typhoid and paratyphoid fever □No □Yes
Epidemic cerebrospinal meningitis □No □Yes

( )

Do you have any of the following diseases or disorders endangering the public order and security?
(Each item must be answered "Yes" or "No")

Toxicomania……□No □Yes
Mental confusion……□No □Yes
Psychosis
Manic paychosis……□No □Yes
Paranoid psychosis……□No □Yes
Hallucinatory……□No □Yes

Height CM	Weight Kg	Blood pressure mmHg
Development	Nourishment	Neck
Vision L_____ R_____	Corrected vision L_____ R_____	Eyes
Colour sense	Skin	Lymph nodes
Ears	Nose	Tonsils
Heart	Lungs	Abdomen

Spine		Extremities		Nervous system	

Other abnormal findings	

X ( ) Chest X-ray exam (attached chest X-ray report)		ECC	

( ) Laboratory exam (attached test report of AIDS, Syphilis etc)	

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None of the following diseases of disorders found during the present examination.

Cholera	Venereal Disease
Yellow fever	Lung tuberculosis
Plague	AIDS
Leprosy	Psychosis

Suggestion

Official Stamp

Signature of physician

Date