

FOREIGNER PHYSICAL EXAMINATION FORM

Name		Sex	<input type="checkbox"/> Male	Birthday		Photo (Stamped Official Stamp)																																										
Present mailing address																																																
Nationality (or Area)		Birth place		Blood type																																												
<p>Have you ever had any of the following diseases? (Each item must be answered "Yes" or "No")</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Typhus fever</td> <td style="width: 10%;"><input type="checkbox"/> No</td> <td style="width: 10%;"><input type="checkbox"/> Yes</td> <td style="width: 50%;">Bacillary dysentery</td> <td style="width: 10%;"><input type="checkbox"/> No</td> <td style="width: 10%;"><input type="checkbox"/> Yes</td> </tr> <tr> <td>Poliomyelitis</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> <td>Brucellosis</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Diphtheria</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> <td>Viral hepatitis</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Scarlet fever</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> <td>Puerperal streptococcus infection</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Relapsing fever</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> <td></td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td colspan="3" style="text-align: center;">Typhoid and paratyphoid fever</td> <td colspan="3" style="text-align: center;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td colspan="3" style="text-align: center;">Epidemic cerebrospinal meningitis</td> <td colspan="3" style="text-align: center;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> </table>							Typhus fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bacillary dysentery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Poliomyelitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Brucellosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Diphtheria	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Viral hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Scarlet fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Puerperal streptococcus infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Relapsing fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Yes	Typhoid and paratyphoid fever			<input type="checkbox"/> No <input type="checkbox"/> Yes			Epidemic cerebrospinal meningitis			<input type="checkbox"/> No <input type="checkbox"/> Yes		
Typhus fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bacillary dysentery	<input type="checkbox"/> No	<input type="checkbox"/> Yes																																											
Poliomyelitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Brucellosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes																																											
Diphtheria	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Viral hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes																																											
Scarlet fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Puerperal streptococcus infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes																																											
Relapsing fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Yes																																											
Typhoid and paratyphoid fever			<input type="checkbox"/> No <input type="checkbox"/> Yes																																													
Epidemic cerebrospinal meningitis			<input type="checkbox"/> No <input type="checkbox"/> Yes																																													
<p>Do you have any of the following diseases or disorders endangering the public order and security? (Each item must be answered "Yes" or "No")</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 80%;">Toxicomania</td> <td style="width: 10%;"><input type="checkbox"/> No</td> <td style="width: 10%;"><input type="checkbox"/> Yes</td> </tr> <tr> <td>Mental confusion</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Psychosis:</td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">Manic psychosis</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td style="padding-left: 20px;">Paranoid psychosis</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td style="padding-left: 20px;">Hallucinatory</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> </tr> </table>							Toxicomania	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Mental confusion	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Psychosis:			Manic psychosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Paranoid psychosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hallucinatory	<input type="checkbox"/> No	<input type="checkbox"/> Yes																								
Toxicomania	<input type="checkbox"/> No	<input type="checkbox"/> Yes																																														
Mental confusion	<input type="checkbox"/> No	<input type="checkbox"/> Yes																																														
Psychosis:																																																
Manic psychosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes																																														
Paranoid psychosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes																																														
Hallucinatory	<input type="checkbox"/> No	<input type="checkbox"/> Yes																																														
Height	CM	Weight	Kg	Blood pressure	mmHg																																											
Development		Nourishment		Neck																																												
Vision	L _____ R _____	Corrected vision	L _____ R _____	Eyes																																												
Colour sense		Skin		Lymph nodes																																												

Spine		Extremities		Nervous system									
Other abnormal findings													
Chest X-ray exam (attached chest X-ray report)													
Laboratory exam (attached test report of AIDS, Syphilis etc)													
<p style="text-align: center;">None of the following diseases of disorders found during the present examination.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Cholera</td> <td style="width: 50%;">Venereal Disease</td> </tr> <tr> <td>Yellow fever</td> <td>Lung tuberculosis</td> </tr> <tr> <td>Plague</td> <td>AIDS</td> </tr> <tr> <td>Leprosy</td> <td>Psychosis</td> </tr> </table>						Cholera	Venereal Disease	Yellow fever	Lung tuberculosis	Plague	AIDS	Leprosy	Psychosis
Cholera	Venereal Disease												
Yellow fever	Lung tuberculosis												
Plague	AIDS												
Leprosy	Psychosis												
Suggestion	Official Stamp												
Signature of physician	Date												