附件 4： 

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 编 | 号 |  | | |  | | |  | |  | |  | |  | |  | | |  | | |  | | |  | |  | | 一寸照片 |
| 姓 | 名 |  | | | | | | | | | | 手机号 | | | |  | | | | | | | | | | | | |
| 身份证号 | |  |  | | |  |  | |  |  | |  |  |  |  |  | |  | |  | |  | |  | |  |  |  |
| 既往病史 | | 肝炎 | | | | | | | |  | | | | | | 主检医师意见：  签名： | | | | | | | | | | | | |
| 结核 | | | | | | | |  | | | | | |
| 皮肤病 | | | | | | | |  | | | | | |
| 性传播性疾病 | | | | | | | |  | | | | | |
| 精神病 | | | | | | | |  | | | | | | 本人签名： | | | | | | | | | | | | | |
| 其他 | | | | | | | |  | | | | | |
| 眼科 | 裸眼视力 | 右： | | | | | | | 矫正视力 | | | | | 右：矫正度数 | | | | | | | | | 检查者 | | | | | | 医师意见：  签名： |
| 左： | | | | | | | 左：矫正度数 | | | | | | | | |
| 色觉检查 | 彩色图案及彩色数码检查： 色觉检查图名称：  单色识别能力检查：（色觉异常者查此项）  红（ ） 黄（ ） 绿（ ） 蓝（ ） 紫（ ） | | | | | | | | | | | | | | | | | | | | | 检查者 | | | | | |
| 眼病 |  | | | | | | | | | | | | | | | | | | | | |
| 内科 | 血压 | / kpa | | | | | | | | | | | | | | | | | | | | | 检查者 | | | | | | 医师意见：  签名： |
| 发育情况 |  | | | | | | | | | | | | | 心脏及血管 | | | | | | | |  | | | | | |
| 呼吸系统 |  | | | | | | | | | | | | | 神经系统 | | | | | | | |  | | | | | |
| 腹部器官 | 肝 | | | | |  |  | | 脾 | | | |  |  |  | |  |  | 肾 | |  |  |  |  |  |  |  |
| 其它 |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 外科 | 身高 | 厘米 | | | | | | | | | | 体重 | | | | | 千克 | | | | | | | 颈部 | | |  | | 医师意见：  签名： |
| 皮肤 |  | | | | | | | | | | 面部 | | | | |  | | | | | | | 关节 | | |  | |
| 脊柱 |  | | | | | | | | | | 四肢 | | | | |  | | | | | | | 检查者 | | | | |
| 其它 |  | | | | | | | | | | | | | | | | | | | | | |
| 耳鼻喉 | 听力 | 左耳 | | | | |  | 米 | |  | 右耳 | | |  | 米 |  | 检查者 | | | | | | |  | | | | | 医师意见：  签名： |
| 嗅觉 |  | | | | | | | | | | | | | | | 检查者 | | | | | | |  | | | | |
| 耳鼻咽喉 |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 口腔科 | 唇腭 |  | | | | | | | | | | | | | | | | | | | 是否口吃 | | | | | |  | | 医师意见：  签名： |
| 牙齿 | （齿缺失——————+——————） | | | | | | | | | | | | | | | | | | |
| 其它 |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 胸透 | 胸部透视 | | | | | | | | | | | | | | | | | | | | 医师意见： | | | | | | | | 签名： |
| 若胸透异常，则进行胸片检查 | | | | | | | | | | | 检查结果: | | | | | | | | | 医师意见： | | | | | | | | 签名： |
| 肝功 | 肝脏功能 | | | | | | | | | | | | | | | | | | | | 医师意见： | | | | | | | | 签名： |
| 若转氨酶异常，需进一步明确诊断 | | | | | | | | | | | 检查结果： | | | | | | | | | 医师意见： | | | | | | | | 签名： |
| 生殖科（仅限申请幼儿园教师资格认定人员） | | 淋球菌 | | | | | | | | | | | |  | | | | | | | | | | | | | | | 主检医师意见：  签名： |
| 梅毒螺旋体 | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| 妇  科 | | 滴虫 | | | | | | | | | |  | | | | | | | | | | | | | | |
| 外阴阴道假丝酵母菌 | | | | | | | | | |  | | | | | | | | | | | | | | |
| 体检  结论 | | 主检医师签名：  年 月 日（医院盖章） | | | | | | | | | | | | | | | | | | | | | | | | | | | |

说明：1.“既往病史”一栏，申请人必须如实填写，如发现有隐瞒严重病史，不符合认定条件者，即使取得资格，一经发现收回认定资格 2.主检医师作体检结论要填写合格、不合格两种结论，并简要说明原因。