**教师资格申请人员体格检查表**

     \_\_\_\_\_\_\_\_市\_\_\_\_\_\_\_\_\_\_\_县（区）            申请资格种类\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | |  |
| 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 | | | | | | | | | | | | | | | | |