山东省医师执业注册健康体检表

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓 名 | |  | | | | 性别 | |  | | | 出生日期 | | | | | | | |  | | | | 近期  二寸免冠  正面半身  彩色照片  （加盖体检  医院公单） |
| 身份证号 | | □□□□□□□□□□□□□□□□□□ | | | | | | | | | | | | | | | | | | | | |
| 工作单位 | |  | | | | | | | | | | | | | | | | | | | | |
| 出 生 地 | |  | | | | | | | | | 民族 | | |  | | | | | | 婚否 | |  |
| 既往病史 | |  | | | | | | | | | | | | | | | | | | | | | |
| 家 族 史 | |  | | | | | | | | | | | | | | | | | | | | | |
| 眼 | 裸眼视力 | | | 左 | |  | | | | | | 右 | | |  | | | | | | | | 医师意见：  签名： |
| 矫正视力 | | |  | | | | | |  | | | | | | | |
| 眼 疾 | | |  | | | | | |  | | | | | | | |
| 色 觉 | | |  | | | | | | | | | | | | | | | | | | |
| 耳  鼻  喉 | 听 力 | | | 左 | |  | | | | | | 右 | | |  | | | | | | | | 医师意见：  签名： |
| 耳 疾 | | |  | | | | | |  | | | | | | | |
| 鼻及鼻窦 | | |  | | | | | |  | | | | | | | |
| 嗅 觉 | | |  | | | | | | | | | | | | | | | | | | |
| 咽 | | |  | | | | | | | | | | | | | | | | | | |
| 喉 | | |  | | | | | | | | | | | | | | | | | | |
| 口  腔 | 粘 膜 | | |  | | | | | | | | | | | | | | | | | | | 医师意见：  签名： |
| 牙及牙龈 | | |  | | | | | | | | | | | | | | | | | | |
| 舌 | | |  | | | | | | | | | | | | | | | | | | |
| 内  科 | 呼吸 | | 次/分 | | | | 脉搏 | | 次/分 | | | | 血压 | | | | / mmHg | | | | | | 医师意见：  签名： |
| 发育及营养 | | | |  | | | | | | | | | | | | | | | | | |
| 神经及精神 | | | |  | | | | | | | | | | | | | | | | | |
| 肺及呼吸道 | | | |  | | | | | | | | | | | | | | | | | |
| 心脏及血管 | | | |  | | | | | | | | | | | | | | | | | |
| 肝、脾、双肾 | | | |  | | | | | | | | | | | | | | | | | |
| 腹部包块 | | | |  | | | | | | | | | | | | | | | | | |
| 其他 | | | |  | | | | | | | | | | | | | | | | | |
| 外  科 | 身 高 | | | | 厘米 | | | | | 体 重 | | | | | | 千克 | | | | | | | 医师意见：  签名： |
| 皮 肤 | | | |  | | | | | 淋巴结 | | | | | |  | | | | | | |
| 头、颈 | | | |  | | | | | 甲状腺 | | | | | |  | | | | | | |
| 脊 柱 | | | |  | | | | | 四 肢 | | | | | |  | | | | | | |
| 肛 门 | | | |  | | | | | 生殖器 | | | | | |  | | | | | | |
| 其 他 | | | |  | | | | | | | | | | | | | | | | | |
| 辅助检查结果 | 胸片 | | | |  | | | | | | | | | | | | | | | | | | 医师签名： |
| 心电图 | | | |  | | | | | | | | | | | | | | | | | | 医师签名： |
| 肝功能 | | | |  | | | | | | | | | | | | | | | | | | 检验师签名： |
| 乙肝两对半 | | | |  | | | | | | | | | | | | | | | | | | 检验师签名： |
| 血常规 | | | |  | | | | | | | | | | | | | 血型 | | |  | | 检验师签名： |
| 尿常规 | | | |  | | | | | | | | | | | | | | | | | | 检验师签名： |
| 体  检  结  果 | 结果：（请在以下项目序号前打“√”表示选定该项体检结果）  ①健康或正常 　　　 ②一般或较弱 　　　 ③有慢性病  ④传染病传染期 　　 ⑤精神病发病期 　　 ⑥身体残疾  说明：一、如选择上述结果③，请继续在下列符合的项目上用“√”表示：  1、心血管病 2、脑血管病 3、慢性呼吸系统病  4、慢性消化系统病 5、慢性肾炎 6、结核病  7、神经或精神疾病 8、糖尿病 9、其他：  二、如选择上述结果④⑤⑥之一者，请具体说明：    体检医院盖章  医师签名： 体检日期： 年 月 日  填报日期： 年 月 日 | | | | | | | | | | | | | | | | | | | | | | |
| 执业机构意见 | 执业机构盖章  负责人签名： 填报日期： 年 月 日 | | | | | | | | | | | | | | | | | | | | | | |