FOREIGNER PHYSICAL EXAMINATIONAL FORM

Full Name	Sex	□Male □Female	Date of birth	dd/mm/yy	photo
Address					
Nationality		Birth place		Blood type	

Have you ever had any of the following diseases or disorders? :

(Each item must be answered "Yes" or "No")

Mental confusion …… □no □yes
Toxicomania …… □no □yes
Personality and behavioral disorders …… □no □yes
Schizophrenia …… □no □yes
Persistent delusional disorders …… □no □yes
Acute and transient psychotic disorders …… □no □yes
Affective disorder …… □no □yes
Psychosis：Manic psychosis …… □no □yes
Paranoid psychosis …… □no □yes
Hallucinatory …… □no □yes
Intellectual disability …… □no □yes
Epilepsy …… □no □yes
Dementia …… □no □yes

Have you ever had any of the following diseases or disorders? :

(Each item must be answered "Yes" or "No")

Leucosis …… □no □yes
Aplastic anemia in the onset or relapse stage …… □no □yes
Type 1 diabetes …… □no □yes
Cirrhosis of the liver …… □no □yes
Chronic kidney disease …… □no □yes
Pulmonary heart disease of any etiology iii stage …… □no □yes
Chronic cardiac failure of any etiology ii b, iii stage …… □no □yes

Height ……cm		Weight ……kg		Blood pressure ……mmhg
Development		Nourishment		Neck
Vision	L	Corrected vision	L	Eyes
	R		R	
Colour sense		Skin		Lymph nodes
Ears		Nose		Tonsils
Heart		Lungs		Abdomen

Spine	Extremities	Nervous system
Other abnormal findings		

Chest X-ray exam		ECC	
Laboratory exam: - HIV - STDs (syphilis, ghonnerhea) - blood test - urinary test			

None of the following diseases of disorders found during the present examination:
Each item must be answered "Yes" or "No")

Cholera …….…... □no □yes
Venereal disease ……..…….…..……..…….. □no □yes
Hemorrhagic fevers Lassa, Marburg, Ebola……..…….…….…….……. □no □yes
Plague……..…….…….…….. □no □yes
AIDS……..…….…….…….…….…… □no □yes
Splenic fever ……..…….…..…….…..……..…….…… □no □yes
Skin disorders (acantholytic, treatment-resistant pemphigus, rapidly progressive skin lymphoma, leprosy)……..…….……..…….……..……..……..… □no □yes
Active tuberculosis of various organs and systems ……..…… □no □yes

Suggestion

Stamp

Signature of physician ……Date