**2020年攻读硕士学位研究生体格检查表**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓 名 | | | |  | | | | | 性 别 | | |  | | | | 出生年月 | | | | |  | | | 照片 | | |
| 民 族 | | | |  | | | | | 职 业 | | |  | | | | 婚 否 | | | | |  | | |
| 籍 贯 | | | |  | | | | | 通讯处 | | |  | | | | | | | | | | | |
| 既往病史 | | | |  | | | | | | | | | | | | | | | | | | | |
| **(以上请考生如实填写)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 五  官  科 | | 眼 | | | 裸眼视力 | | | 右: | | | | | | | 矫正视力 | | | 右: | | | | | | | | 医师意见  (签字)  眼科  耳鼻喉科  口腔科 |
| 左: | | | | | | | 左: | | | | | | | |
| 其他眼疾 | | |  | | | | | | | 色觉检查 | | |  | | | | | | | |
| 耳 | | | 听力 | | | 右: | | | | | | | 耳疾 | | |  | | | | | | | |
| 左: | | | | | | |
| 鼻 | | | 嗅觉 | | |  | | | | | | | 鼻及鼻窦疾病 | | | | | | |  | | | |
| 颜面部 | | |  | | | | | | | | | | 咽喉 | | |  | | | | | | | |
| 口腔 | | | 唇 | | |  | | | | | | | 门齿 | | |  | | | | | | | |
| 其他 | | |  | | | | | | | | | | | | | | | | | | | | |
| 外  科 | | 身高 | | | 公分 | | | | | 体重 | | | 公斤 | | | | | | 皮肤 | | |  | | | | 医师意见  (签字) |
| 淋巴 | | |  | | | | | 甲状腺 | | |  | | | | | | 脊柱 | | |  | | | |
| 四肢 | | |  | | | | | | | | | | | | | | | | | | | | |
| 关节 | | |  | | | | | | | 足 | | |  | | | | | | | | | | |
| 其他 | | |  | | | | | | | | | | | | | | | | | | | | |
| 内科 | 血压 | | | |  | | | | | | | | | 心率 | | | | | |  | | | | | 医师意见  (签字) | |
| 发 育 及  营养状况 | | | |  | | | | | | | | | | | | | | | | | | | |
| 神 经  及 精 神 | | | |  | | | | | | | | | | | | | | | | | | | |
| 肺 及  呼 吸 道 | | | |  | | | | | | | | | | | | | | | | | | | |
| 心 脏  及 血 管 | | | |  | | | | | | | | | | | | | | | | | | | |
| 腹部器官 | | | | 肝 | |  | | | | | | | | | | | | | | | | | |
| 脾 | |  | | | | | | | | | | | | | | | | | |
| 其他 | | | |  | | | | | | | | | | | | | | | | | | | |
| 化验检查  (要附化验单据) | | | | | 血 | |  | | | | 谷丙转氨酶(ALT) | | | | | |  | | | | | | 尿 | |  | |
| 胸部放射线检查 | | | | | | 医师签字: | | | | | | | | | | | | | | | | | | | | |
| 其他检查 | | | | | |  | | | | | 口吃 | | |  | | | | | | 外貌异常 | | | | |  | |
| 体检结论 | | | | | | 负责医师签章: | | | | | | | | | | | | | | | | | | | | |
| 体检医院意见 | | | | | | 体检医院盖章: | | | | | | | | | | | | | | | | | | | | |
| 复审意见 | | | | | | 复审单位盖章 | | | | | | | | | | | | | | | | | | | | |
| 备 注 | | |  | | | | | | | | | | | | | | | | | | | | | | | |

体检日期:2020年 月 日