FOREIGNER PHYSICAL EXAMINATION FORM

Name		Sex	☐ Male ☐ Female	Birthday		( )
Present mailing address						Photo (Stamped Official Stamp)
Nationality (or Area)		Birth place		Blood type		

“ ” “ ”

Have you ever had any of the following diseases?
(Each item must be answered “Yes” or “No”)

Typhus fever ☐No ☐Yes
Poliomyelitis ☐No ☐Yes
Diphtheria ☐No ☐Yes
Scarlet fever ☐No ☐Yes
Relapsing fever ☐No ☐Yes
Bacillary dysentery ☐No ☐Yes
Brucellosis ☐No ☐Yes
Viral hepatitis ☐No ☐Yes
Puerperal streptococcus infection ☐No ☐Yes
Typhoid and paratyphoid fever ☐No ☐Yes
Epidemic cerebrospinal meningitis ☐No ☐Yes

(“ ” “ ”)

Do you have any of the following diseases or disorders endangering the public order and security?
(Each item must be answered “Yes” or “No”)

Toxicomania……☐No ☐Yes
Mental confusion……☐No ☐Yes
Psychosis: Manic paychosis……☐No ☐Yes
Paranoid psychosis……☐No ☐Yes
Hallucinatory……☐No ☐Yes

Height CM	Weight Kg	Blood pressure mmHg
Development	Nourishment	Neck
Vision L_____ R_____	Corrected vision L_____ R_____	Eyes
Colour sense	Skin	Lymph nodes

Spine		Extremities		Nervous system	

Other abnormal findings	

X ( ) Chest X-ray exam (attached chest X-ray report)		ECC	

( ) Laboratory exam (attached test report of AIDS, Syphilis etc)	

:

None of the following diseases of disorders found during the present examination.

Cholera	Venereal Disease
Yellow fever	Lung tuberculosis
Plague	AIDS
Leprosy	Psychosis

Suggestion

Official Stamp

Signature of physician

Date