

FOREIGNER PHYSICAL EXAMINATION FORM

Name		Sex	☐ Male ☐ Female	Birthday		Photo (Stamped Official Stamp)
Present mailing address						
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	Bacillary dysentery ☐ No ☐ Yes
Poliomyelitis ☐ No ☐ Yes	Brucellosis ☐ No ☐ Yes
Diphtheria ☐ No ☐ Yes	Viral hepatitis ☐ No ☐ Yes
Scarlet fever ☐ No ☐ Yes	Puerperal streptococcus infection
Relapsing fever ☐ No ☐ Yes	☐ 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 psychosis.....	☐ 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	
Ears		Nose		Tonsils	
Heart		Lungs		Abdomen	

Spine		Extremities		Nervous system									
Other abnormal findings													
Chest X-ray exam (attached chest X-ray report)													
Laboratory exam (attached test report of AIDS, Syphilis etc)													
None of the following diseases of disorders found during the present examination. <table> <tr> <td>Cholera</td> <td>Venereal Disease</td> </tr> <tr> <td>Yellow fever</td> <td>Lung tuberculosis</td> </tr> <tr> <td>Plague</td> <td>AIDS</td> </tr> <tr> <td>Leprosy</td> <td>Psychosis</td> </tr> </table>						Cholera	Venereal Disease	Yellow fever	Lung tuberculosis	Plague	AIDS	Leprosy	Psychosis
Cholera	Venereal Disease												
Yellow fever	Lung tuberculosis												
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Suggestion Official Stamp Signature of physician Date													