

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					

