宝鸡文理学院人事代理制人员招聘体检表

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓 名 | | |  | | | | | | | 性别 |  | | | | 出生 | | 年 月 日 | | | | | | | 半身一寸  脱帽照片  （教师资格认定办公室印章） | |
| 身份证号 | | |  | | | | | | | | | | | | 民族 | |  | | | 婚否 | | |  |
| 联系电话 | | |  | | | | | | | 工作单位或  毕业学校 | | | | |  | | | | | | | | |
| 现住所及通讯处 | | | | |  | | | | | | | | | | | | | | | | | | |
| 既往病史 | | | 性传播性疾病、皮肤病、心脏病、肾炎、肝炎、关节炎、哮喘、癫痫、结核、  精神病等（以上请本人如实填写，对应处划“√”，并写明患病时间。）  确认签名： 日期：20 年 月 日 | | | | | | | | | | | | | | | | | | | | | | |
| 五  官  科 | 眼 | | | 视力 | | | 左 | | | | | | | | | | | 辨色 | | |  | | | 医师签字 | |
| 右 | | | | | | | | | | |
| 矫正  视力 | | | 左 | | | | | | | | | | | 其他眼病 | | |  | | |
| 右 | | | | | | | | | | |
| 耳 | | | 听力 | | | 左 米 | | | | | | | 耳疾 | | | |  | | | | | | 医师签字 | |
| 右 米 | | | | | | |
| 口鼻 | | | 嗅觉 | | |  | | | | | 鼻及鼻窦 | | | | | |  | | | | | |
| 口吃 | | |  | | | | | 咽喉 | | | |  | | | | | | | |
| 唇颚 | | |  | | | | | 门齿 | | | |  | | | | | | | |
| 颜面部 | | | | | |  | | | | | 其他 | | | |  | | | | | | | |
| 外  科 | 身高 | | | 公分 | | | | | | | | 体重 | | | | 公斤 | | | | | | | | 医师签字 | |
| 淋巴 | | |  | | | | | | | | 皮肤 | | | |  | | | | | | | |
| 四肢 | | |  | | | | | | | | 甲状腺 | | | |  | | | | | | | |
| 关节 | | |  | | | | | | | | 胸廓 | | | |  | | | | | | | |
| 外貌  异常 | | |  | | | | | | | | 脊柱 | | | |  | | | | | | | |
| 平跖足 | | |  | | | | | | | | 其他 | | | |  | | | | | | | |
| 内  科 | | | 血 压 | | | | 千帕 毫米汞柱 | | | | | | | | | | | | | | | | | | | 医师签字 | |
| 心 率  （次）/分 | | | |  | | | | | | | | | | | | | | | | | | |
| 发育及营养状况 | | | |  | | | | | | | | | | | | | | | | | | |
| 肺及呼吸道 | | | |  | | | | | | | | | | | | | | | | | | |
| 心 脏 | | | |  | | | | | | | | | | | | | | | | | | |
| 腹部B超 | | | | 肝 | | |  | | | | | | | | | | | | | | | |
| 脾 | | |  | | | | | | | | | | | | | | | |
| 神经及精神 | | | |  | | | | | | | | | | | | | | | | | | |
| 其他 | | | |  | | | | | | | | | | | | | | | | | | |
| 妇科检查 | | | | | | |  | | | | | | | | | | | | | | | | | | | 医师签字 | |
| 心 电 图 | | | | | | |  | | | | | | | | | | | | | | | | | | | 医师签字 | |
| 胸部X线 | | | | | | |  | | | | | | | | | | | | | | | | | | | 医师签字 | |
| 化验检查  （另附化验单） | | | | | | | 血液 | |  | | | | | 化验员签字 | | | | | | 尿液 | | |  | | | 化验员签字 | |
| 体检结论 | | | | | | | （填写合格、不合格、受限结论，不合格和受限的须注明原因。） | | | | | | | | | | | | | | | | | | | 负责医师  签 字 | |
| 体检医院  意 见 | | | | | | | 医院公章  20 年 月 日 | | | | | | | | | | | | | | | | | | | | |

说明：（1）既往病史一栏，必须如实填写，在病名上划“√”，并写明患病时间。如发现有隐瞒严重病史，不符合认定条件者，即使取得资格，一经发现取消资格。（2）体检时须携带本人身份证，在规定的体检时间空腹到指定医院参加体检。由于本人不按规定时间和要求进行体检，造成不能体检或体检项目不完整的视为体检不合格。（3）各种检验单随表粘贴。（4）此表请用A4纸正反印制，请提前填写完基本信息并贴上照片。