江西省教师资格申请人员

体

检

表

江 西 省 教 育 厅 制体 检 须 知

为了准确反映受检者身体的真实状况，请注意以下事项：

1.均应到指定医院进行体检，其它医疗单位的检查结果一律无效。

2.严禁弄虚作假、冒名顶替；如隐瞒病史影响体检结果的，后果自负。

3.体检表上粘贴近期正面一寸免冠彩色白底照片一张。

4.本表第一页由受检者本人填写（用黑色签字笔或钢笔），要求字迹清楚，无涂改，病史部分要如实、逐项填齐，不能遗漏。

5.体检前一天请注意休息，勿熬夜，不要饮酒，避免剧烈运动。

6.体检当天需进行采血、B超等检查，请在受检前禁食8-12小时。

7.女性受检者月经期间请勿做妇科及尿液检查，待经期完毕后再补检；怀孕或可能已受孕者，事先告知医护人员，勿做X光检查。

8.请配合医生认真检查所有项目，勿漏检。若自动放弃某一检查项目，将会影响对您的教师资格认定。

9.体检医师可根据实际需要，增加必要的相应检查、检验项目。

10.如对体检结果有疑义，请按有关规定办理。

江西省教师资格申请人员体检表

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **姓 名** |  | | | | | **性 别** | | |  | | | | | **出生年月** | | |  | | | | | 近  期  照  片 | |
| **民 族** |  | | | | | **婚姻状况** | | |  | | | | | **籍 贯** | | |  | | | | |
| **联系电话** |  | | | | | **通讯地址** | | |  | | | | | | | | | | | | |
| **申请资格**  **种类** |  | | | | | **身份证号** | | |  | | | | | | | | | | | | |
| 请本人如实详细填写下列项目  （在每一项后的空格中打“√”回答“有”或“无”，如故意隐瞒，责任自负） | | | | | | | | | | | | | | | | | | | | | | | |
| **病名** | **有** | | **无** | | | | **治愈时间** | | | | **病 名** | | | | | **有** | | | | **无** | | **治愈时间** | |
| **高血压病** |  | |  | | | |  | | | | **糖尿病** | | | | |  | | | |  | |  | |
| **冠心病** |  | |  | | | |  | | | | **甲亢** | | | | |  | | | |  | |  | |
| **风心病** |  | |  | | | |  | | | | **贫血** | | | | |  | | | |  | |  | |
| **先心病** |  | |  | | | |  | | | | **癫痫** | | | | |  | | | |  | |  | |
| **心肌病** |  | |  | | | |  | | | | **精神病** | | | | |  | | | |  | |  | |
| **支气管扩张** |  | |  | | | |  | | | | **神经官能症** | | | | |  | | | |  | |  | |
| **支气管哮喘** |  | |  | | | |  | | | | **吸毒史** | | | | |  | | | |  | |  | |
| **肺气肿** |  | |  | | | |  | | | | **急慢性肝炎** | | | | |  | | | |  | |  | |
| **消化性溃疡** |  | |  | | | |  | | | | **结核病** | | | | |  | | | |  | |  | |
| **肝硬化** |  | |  | | | |  | | | | **性传播疾病** | | | | |  | | | |  | |  | |
| **胰腺疾病** |  | |  | | | |  | | | | **恶性肿瘤** | | | | |  | | | |  | |  | |
| **急慢性肾炎** |  | |  | | | |  | | | | **手术史** | | | | |  | | | |  | |  | |
| **肾功能不全** |  | |  | | | |  | | | | **严重外伤史** | | | | |  | | | |  | |  | |
| **结缔组织病** |  | |  | | | |  | | | | **其他** | | | | |  | | | |  | |  | |
| **备 注：** |  | | | | | | | | | | | | | | | | | | | | | | |
| **受检者签字：**    **体检日期： 年 月 日** | | | | | | | | | | | | | | | | | | | | | | | |
| **身高** | 厘米 | | | | | | **体重** | | | 公斤 | | | | | **血压** | | | | / mmHg | | | | |
| **内**  **科** | 病史：曾患过何种疾病（起病时间及目前症状）。 | | | | | | | | | | | | | | | | | | | | | | |
| 心脏 | | | | 心界  杂音 | | | | | | | | 心率 | | | | | 次/分 律 | | | | | |
| 肺 | | | |  | | | | | | | | 腹部 | | | | |  | | | | | |
| 肝 | | | |  | | | | | | | | 神经系统 | | | | |  | | | | | |
| 脾 | | | |  | | | | | | | | 其他 | | | | |  | | | | | |
| 建议 | | | |  | | | | | | | | | | | | | 医师签字 | | | | |  |
| **外**  **科** | 病史：曾做过何种手术或有无外伤史（名称及时间），目前功能如何。 | | | | | | | | | | | | | | | | | | | | | | |
| 皮肤 | | | |  | | | | | | | | 浅表  淋巴结 | | | | |  | | | | | |
| 头颅 | | | |  | | | | | | | | 甲状腺 | | | | |  | | | | | |
| 乳腺 | | | |  | | | | | | | | 脊柱  四肢关节 | | | | |  | | | | | |
| 肛门  外生殖器 | | | |  | | | | | | | | 其他 | | | | |  | | | | | |
| 建议 | | | |  | | | | | | | | | | | | | 医师签字 | | | | |  |
| **眼**  **科** | 裸眼视力 | | | | 右 | | | | | 矫正视力 | | 右 | | | | | | 医师签字 | | | | |  |
| 左 | | | | | 左 | | | | | |
| 色觉 | | | |  | | | | | | | | | | | | | | | | | | |
| 其他 | | | |  | | | | | | | | | | | | | | | | | | |
| 建议 | | | |  | | | | | | | | | | | | | 医师签字 | | | | |  |
| **耳**  **鼻**  **喉**  **科** | 听力 | | | | 左耳  右耳 | | | | | | | | | | | | | 耳部 | | | | |  |
| 鼻部 | | | |  | | | | | | | | | | | | | 咽部 | | | | |  |
| 喉部 | | | |  | | | | | | | | | | | | | 嗅觉 | | | | |  |
| 其他 | | | |  | | | | | | | | | | | | | | | | | | |
| 建议 | | | |  | | | | | | | | | | | | | 医师签字 | | | | |  |
| **口**  **腔**  **科** | | 唇腭舌 | |  | | | | | | | | | 牙齿 | |  | | | | | | | | |
| 是否口吃 | |  | | | | | | | | | | | | | | | | | | | |
| 其他 | |  | | | | | | | | | | | | | | | | | | | |
| 建议 | |  | | | | | | | | | | | 医师签字 | | | | | |  | | |
| **妇科检查** | |  | | | | | | | | | | | | | 医师签字 | | | | | |  | | |
| **心电图** | |  | | | | | | | | | | | | | 医师签字 | | | | | |  | | |
| **胸部X光片** | |  | | | | | | | | | | | | | 医师签字 | | | | | |  | | |
| **腹部B超**  **检查** | |  | | | | | | | | | | | | | 医师签字 | | | | | |  | | |
| **申请幼儿**  **教师资格**  **加测** | | **妇科** | | 滴虫 | | | |  | | | | | | | 医师签字 | | | | | |  | | |
| 念球菌 | | | |  | | | | | | |
| 注：对于滴虫和念球菌两项妇科检查项目未婚女性采取阴道口取样。 | | | | | | | | | | | | | | | | | | | | | | | |
| **体检结论**  **及建议** | | 主检医师签字： 体检医院签章处  年 月 日 | | | | | | | | | | | | | | | | | | | | | |