FOREIGNER PHYSICAL EXAMINATION FORM

Name			Sex	Male Female	Birthday		()			
Present mailing address					Photo						
Nationality (or Area)		Birth place		Blood type		(Stamped Of Stamp)					
Have you ever had any of the following diseases? (Each item must be answered "Yes" or "No")											
Poliomyelitis I Diphtheria I Scarlet fever N			No No No No	Yes Yes Yes Yes	Bruc Vira	llary dysenter cellosis l hepatitis peral streptoc	y No No No occus infection No	Yes Yes 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											
Height	t	CM	W€	eight	Kg	Blood press	ure n	nmHg			
Develo	opment		No	ourishment		Neck					
L Vision R			Co	rrected vision	L R	Eyes					
Colour sense			Sk	in		Lymph nodes					
Ears			No	ose		Tonsils					
Heart			Lu	ngs		Abdomen					

Spine			Extremities			Nervous system			
Other abnormal findings									
(attache	X) X-ray exam ed chest X-ray report)				ECC				
(attache) ratory exam d test report of Syphilis etc)								

None of the following diseases of disorders found during the present examination. Cholera $\,$