|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 眼科 | 色觉  裸眼视力 | | 右 | 矫正视力 | 右 | | 医师签字 |  |
| 左 | 左 | |
|  | |  | | | | | |
| 其他 | | 医师签字 | | | | | |
| 建议 | | 右耳 | | | |  |  |
| 耳鼻喉科 | 左耳  听力 | |  | | | 耳部 |  | |
|  | | |
| 鼻部 | |  | | | 咽部 |  | |
| 其他  喉部 | |  | | | 嗅觉 |  | |
| 建议 | | 医师签字 | | | | | |
|  | | 颞下颌关节 | | | |  |  |
| 口腔科 | 唇腭舌  腮腺 | |  | | | 口腔黏膜 |  | |
| 其他 | |  | | |  |  | |
| 建议 | | 医师签字 | | | | | |
|  | |  | | | |  |  |
| 心电图 | | 建议：  医师签字： | | | | | | |
| 胸部X光 | | 建议：  医师签字： | | | | | | |
| 腹部  B超 | | 建议：  医师签字： | | | | | | |
| 体检  结论  及建  议 | | 结论及建议：  体检医院签章处  主检医师签字： 年 月 日 | | | | | | |

序号：

**事 业 单 位 聘 用**

**体 检 表**

**人力资源社会保障部**

**制**

**卫 生 部**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓 名 | | |  | | | | | | 性 别 | | |  | | | 出生年月 | | | |  | | | | 2寸  照片  （近期免冠） | | | |
| 民 族 | | |  | | | | | | 婚姻状况 | | |  | | | 籍 贯 | | | |  | | | |
| 文化程度 | | |  | | | | | | 联系电话 | | |  | | | | | | | | | | |
| 职 业 | | |  | | | | | | 工作单位 | | |  | | | | | | | | | | |
| 报考职位 | | |  | | | | | | 身份证号 | | |  | | | | | | | | | | |
| 请本人如实填写如下项目  （在每一项后空格中打“√”以回答“有”或“无”，如故意隐瞒，后果自负） | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 病 名 | | | | 有 | | | | 无 | | 治愈时间 | | | 病 名 | | | | | 有 | | | | 无 | | 治愈时间 | | |
| 高血压 | | | |  | | | |  | |  | | | 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 | | | | 血型 | | |  | | | 血压 | | | **/** | | | |
| 检 验 项 目 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 血 常 规 | | | | | | 白细胞总数(WBC)及分类 | | | | | 血红蛋白（HGB） | | | | | 红细胞总数（RBC） | | | | | 血小板计数（PLT） | | | | |  | |
| 血 生 化 | | | | | | 丙氨酸氨基转移酶（ALT） | | | | | 尿素氮（BUN） | | | | | 天冬氨酸氨基转移酶（AST） | | | | | 肌酐（CR） | | | | | 葡萄糖（GLU） | |
| 免 疫 | | | | | | 艾滋病病毒抗体（抗HIV） | | | | | | | | | | 梅毒血清特异性抗体（TPHA） | | | | | | | | | |  | |
| 尿 常 规 | | | | | | 糖（GLU） | | | | | 蛋白质（PRO） | | | | | 胆红素（TBIL） | | | | | 尿胆原（URO） | | | | | 比重（SG） | |
| 红细胞（BLO） | | | | | 酸碱度（PH） | | | | | 白细胞（LEU） | | | | | 镜检 | | | | |  | |
| 其他： | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 内科 | 病史：曾患过何种疾病（起病时间及目前症状）。 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 心脏 | | | | | | 心界 | | | | | | | | | 心率 次/分 律 | | | | | | | | | | | |
| 杂音 | | | | | | | | |
| 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 | | | | |  | | |