ImmerQi

TEACH I INTERN I VOLUNTEER I MANDARIN

Medical Record Verification Form

Instructions: This form must be completed by a non-relative physician. All references must be in English or translated into English with the original document attached.

Name		Sex □Male □Female	Date of Birth y.____ m.__ d.__	photo (put hospital seal across the photo)
Present mailing address			Blood Type	
Nationality		Birth Place		

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	□No□Yes
Relapsing fever	□No□Yes	Infection	□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 secure?
(Each item most be answered "Yes" or "No")

Toxicomania……□No□Yes
Mental confusion……□No□Yes
Psychosis：Manic psychosis……□No□Yes
Paranoid psychosis……□No□Yes
Hallucinatory psychosis……□No□Yes

Height(cm)	Weight(kg)	Blood Pressure (mmHg)
Development	Nourishment	Neck

Vision	L R	Corrected vision	L R	Eyes
Color sense		Skin		Lymph nodes
Ears		Nose		Tonsils
Heart		Lungs		Abdomen

Spine	Extremities	Nervous system
Any physical abnormalities or disabilities which can be seen or unseen:		
None of the following diseases or disorders found during the present examination. Cholera Yellow fever Plague Leprosy Venereal Disease Opening lung tuberculosis AIDS Psychosis		
Suggestion Signature of physician	Official Stamp Date	