의사발급 공식건강검진표
(Official Medical Examination)

1. Personal Information

Full Name: Gender:

Date of Birth: Nationality:

2. Physical Examination

Blood Pressure: Systolic _____ Diastolic _____mmHg

Vision: Right 20/_____Left 20/_____Color Vision _____

Corrected: Right _____/15 Left_____/15

Dental Evaluation: ☐Good ☐Fair ☐Poor ☐Needs Attention

Clinical Evaluation:

Classification	Normal	Abnormal	Classification	Normal	Abnormal
Skin			Heart		
Head & Face			Abdomen		
Eyes			Extremities		
Ears			Back & Spine		
Mouth & Throat			Neurological		
Nose & Sinuses			Mental Health		
Neck					
Chest & Lungs					
Other					

If abnormal, please specify:_____

3. Chest X-ray Examination

- Date taken:_____
- Findings:_____

4. Laboratory Examination

Hemoglobin: _____Gm/dl _____ Urine: S.G. _____Sugar _____Micro_____

Hepatitis B: _____ Stool Oval & Parasite Test:_____

Serological Test for Syphilis:_____

TBPE:_____ **OR** Drug Test: MA( ) COC( ) OPI( ) THC( )

Other:_____

In my opinion his/her health condition is;

☐Excellent ☐Good ☐Fair ☐Poor

This is to certify that the above named applicant has gone through a general medical examination and the findings indicated here are true to the best of my knowledge.

Date	
M.D	
Signature	

Hospital and Contact Information