**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**

UNI000001dc0451 Date taken:

UNI000001dc0453 Findings:

**4. Laboratory Examination**

Hemoglobin: Gm/dl Urine: S.G. Sugar Micro

UNI000001dc0455Hepatitis B:  Stool Oval & Parasite Test:

UNI000001dc0459Serological 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 |  |  | Hospital and Contact Information |
| M.D |  |  |
| Signature |  |