

附件4：

安徽外国语学院外籍交换生健康信息调查表

HEALTH PROFILE FOR FOREIGN EXCHANGE STUDENTS TO ANHUI INTERNATIONAL STUDIES UNIVERSITY

姓名 Name		性别 Sex	<input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	出生日期 DOB		照片 Photo
现在通信地址 Present mailing address						
国籍 Nationality		出生地址 Birth Place		血型 Blood type		
<p>过去是否患有下列疾病：（每项后面请回答“是”或“否”）</p> <p>Have you ever had any of the following diseases? (Each item must be answered with “Yes” or “No”)</p>						
斑疹伤寒 Typhus fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	菌痢 Bacillary dysentery	<input type="checkbox"/> No <input type="checkbox"/> Yes			
小儿麻痹症 Poliomyelitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	布氏杆菌病 Brucellosis	<input type="checkbox"/> No <input type="checkbox"/> Yes			
白喉 Diphtheria	<input type="checkbox"/> No <input type="checkbox"/> Yes	病毒性肝炎 Viral hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes			
猩红热 Scarlet fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	产褥期链菌 Puerperal streptococcus infection	<input type="checkbox"/> No <input type="checkbox"/> Yes			
回归热 Relapsing fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	感染				
伤寒和副伤寒 Typhoid and paratyphoid fever	<input type="checkbox"/> No <input type="checkbox"/> Yes					
流行性脑脊髓膜炎 Epidemic cerebrospinal meningitis	<input type="checkbox"/> No <input type="checkbox"/> Yes					
<p>是否患有下列危机公共秩序和安全的病症：（每项后面请回答“是”或“否”）</p> <p>Do you have any of the following diseases or disorders endangering the public order and security? (Each item must be answered with “Yes” or “No”)</p>						
毒物瘾 Toxicomania		<input type="checkbox"/> No <input type="checkbox"/> Yes			
精神错乱 Mental confusion		<input type="checkbox"/> No <input type="checkbox"/> Yes			
精神病 Psychosis:	躁狂型 Manic Psychosis	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	妄想型 Paranoid psychosis	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	幻觉型 Hallucinatory psychosis	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	抑郁症 Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes			
<p>是否患有其他需要定期治疗的疾病？如果有，请在下方备注。</p> <p>Do you have any other medical conditions that require regular treatment? If YES, please comment below.</p>						
姓名/Name:						日期/Date: YY MM DD

签名/Signature: