Patient Name: John Parker

Age: 45

Gender: Male

Date of Birth: 1978-04-15

Report Date: 2025-01-12

1. Medical History

John has a history of hypertension and type 2 diabetes. No history of surgeries or major illnesses.

2. Blood Test Results

Complete Blood Count (CBC):

- WBC: 6,000 /µL (Normal)

- RBC: 4.8 million /µL (Normal)

- Hemoglobin: 14.5 g/dL (Normal)

Lipid Profile:

- Total Cholesterol: 180 mg/dL (Desirable)

- HDL: 55 mg/dL (Good)

- LDL: 110 mg/dL (Near optimal)

- Triglycerides: 150 mg/dL (Borderline high)

3. Imaging Reports

Chest X-ray: Clear, no abnormalities detected.

Abdominal Ultrasound: Normal liver and kidney function. No signs of masses or lesions.

4. Cardiac Assessments

ECG Report:

- Normal sinus rhythm observed.
- No signs of ischemia or infarction.
- Heart rate: 72 bpm (Normal).

5. Urinalysis

- Color: Light yellow

- pH: 6.0

- Specific Gravity: 1.020 (Normal)

- Proteins: Negative

- Glucose: Negative

6. Endocrine Profile

Thyroid Function Test:

- TSH: 2.5 µIU/mL (Normal)

- Free T3: 3.0 pg/mL (Normal)

- Free T4: 1.2 ng/dL (Normal)

7. General Observations

John appears in good overall health. BMI: 24.8 kg/m² (Normal). No signs of distress observed during the physical examination.

8. Diagnosis Summary

- Hypertension: Well-controlled with current medication.
- Type 2 Diabetes: Stable, with recent HbA1c at 6.5%.
- Lipid Profile: Borderline triglycerides, recommend dietary changes.

9. Recommendations

- Continue current medications for hypertension and diabetes.
- Incorporate a low-fat, high-fiber diet to improve lipid profile.
- Regular exercise: 30 minutes daily, 5 days a week.
- Follow-up in 6 months for reassessment.