MEDICAL RECORD: GENERAL CHECK-UP REPORT

PATIENT INFORMATION

Name: John Doe
Date of Birth: 05/15/1980
Patient ID: P-1001
Date of Examination: April 15, 2023
Examining Physician: Dr. Sarah Johnson

VITAL SIGNS

Blood Pressure: 130/85 mmHg
Heart Rate: 78 bpm
Respiratory Rate: 16 breaths/min
Temperature: 98.6´℉ $$37´℃$$
Weight: 180 lbs $$81.6 kg$$
Height: 5’10" $$178 cm$$
BMI: 25.8 $$Overweight$$

PHYSICAL EXAMINATION

General Appearance: Patient is well-groomed and in no apparent distress
HEENT: Normocephalic, atraumatic. Pupils equal, round, and reactive to light.
Cardiovascular: Regular rate and rhythm. No murmurs, gallops, or rubs.
Respiratory: Clear to auscultation bilaterally. No wheezes or crackles.
Abdomen: Soft, non-tender, non-distended. No hepatosplenomegaly.
Extremities: No edema, cyanosis, or clubbing. Pulses 2+ throughout.
Neurological: Alert and oriented x3. Cranial nerves II-XII intact.

ASSESSMENT

1. Hypertension - Well-controlled on current medication
2. Type 2 Diabetes Mellitus - Stable, HbA1c within target range
3. Hyperlipidemia - Improved since last visit
4. Overweight - Discussed lifestyle modifications

PLAN

1. Continue current medications:
   - Lisinopril 10mg daily
   - Metformin 500mg twice daily
   - Atorvastatin 20mg at bedtime
2. Laboratory tests ordered: Complete blood count, comprehensive metabolic panel, lipid panel
3. Follow-up appointment in 3 months
4. Recommended dietary changes and moderate exercise program

This document is part of the patient’s medical record and is confidential.

Electronically signed by: Dr. Sarah Johnson, MD
Date: April 15, 2023