

Comprehensive Medical Report

Date: January 03, 2025

Patient Name: Patient 1265

Age: 50, Gender: Male, Marital Status: Widowed

The patient presented with a history of hypertension, currently undergoing treatment with aspirin. The family history reveals instances of heart disease, indicating a potential genetic predisposition to certain conditions. The patient reports a sedentary lifestyle with moderate physical activity and follows a balanced diet. Sleep patterns are described as irregular with stress levels reported as low.

--- Vaccination History ---

- Smallpox: Fully vaccinated. The patient has received the recommended immunizations, including recent booster shots, enhancing their immunity profile.
- Polio: Booster dose received. The patient has received the recommended immunizations, including recent booster shots, enhancing their immunity profile.
- Diphtheria: Vaccinated. The patient has received the recommended immunizations, including recent booster shots, enhancing their immunity profile.
- Tetanus: Recent booster. The patient has received the recommended immunizations, including recent booster shots, enhancing their immunity profile.
- Tuberculosis: Negative test. The patient has received the recommended immunizations, including recent booster shots, enhancing their immunity profile.
- COVID-19: Fully vaccinated. The patient has received the recommended immunizations, including recent booster shots, enhancing their immunity profile.

--- Physical Examination ---

The patient stands 154 cm tall, with a weight of 83 kg. Body temperature recorded at 37.3 °C. Chest girth measurements indicate 108 cm cm during inspiration and 102 cm cm during expiration. Skin examination revealed eczema with no visible lesions or infections.

--- Vision and ENT Examination ---

Vision tests revealed right eye acuity of 20/35 and left eye acuity of 20/20. Color vision assessment indicated normal with a full range of field vision. Ophthalmologist's opinion: fit.

ENT examination findings: Normal hearing, no wax buildup, Normal, clear tympanic membrane. Nasal passages showed no signs of congestion, and the throat appeared no inflammation, normal tonsils.

--- Circulatory, Respiratory, and Nervous System ---

Circulatory assessment revealed a pulse of 75 bpm and blood pressure at 121/70 mmHg.

Respiratory evaluation showed lungs clear, no abnormal sounds, normal respiratory effort with normal breathing patterns. Nervous system examination indicated no neurological deficits.

--- Urine Analysis and Mental Health ---

Urinalysis revealed Clear, pale yellow. Albumin: Negative, Sugar: Negative.

Mental health evaluation indicated good social and emotional adjustment capabilities.

Emotional health showed mild anxiety during stress events. No signs of substance abuse or psychotic disorders were reported.

--- Board Assessment ---

Final Assessment: Fit

--- Recommendations ---

- Increase physical activity. The patient was advised to follow a personalized health plan.
- Balanced diet. The patient was advised to follow a personalized health plan.
- Stress management techniques. The patient was advised to follow a personalized health plan.
- Regular cardiovascular screenings. The patient was advised to follow a personalized health plan.