Comprehensive Medical Report

Date: June 30, 2023

Patient Name: Patient 4336

Age: 65, Gender: Female, Marital Status: Single

The patient presented with a history of coronary artery disease, currently undergoing treatment with metformin. The family history reveals instances of cancer, indicating a potential genetic predisposition to certain conditions. The patient reports a occasional drinker with moderate physical activity and follows a vegetarian. 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 162 cm tall, with a weight of 89 kg. Body temperature recorded at 37.2 °C. Chest girth measurements indicate 96 cm cm during inspiration and 85 cm cm during expiration. Skin examination revealed healthy with no visible lesions or infections.

--- Vision and ENT Examination ---

Vision tests revealed right eye acuity of 20/33 and left eye acuity of 20/36. Color vision assessment indicated severe deficiency with a full range of field vision. Ophthalmologist's opinion: unfit.

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 98 bpm bpm and blood pressure at 120/87 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 adjustment capabilities.

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

--- Board Assessment ---

Final Assessment: Unfit

--- 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.