

Comprehensive Medical Report

Date: May 18, 2021

Patient Name: Patient 5672

Age: 62, Gender: Female, Marital Status: Married

The patient presented with a history of diabetes, currently undergoing treatment with lisinopril. The family history reveals instances of hypertension, indicating a potential genetic predisposition to certain conditions. The patient reports a smoker with moderate physical activity and follows a high-fat diet. Sleep patterns are described as insomnia tendencies 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 179 cm tall, with a weight of 74 kg. Body temperature recorded at 37.2 °C. Chest girth measurements indicate 110 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 20/25 and left eye acuity of 20/31. 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 79 bpm and blood pressure at 110/80 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: 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.