

COMPREHENSIVE HEALTH ASSESSMENT REPORT

Patient Name: John Doe
Date of Birth: 15/03/1985
Age: 40 years
Gender: Male
Report Date: 01/12/2025
Report ID: HCR-2025-001847

EXECUTIVE SUMMARY

This comprehensive health assessment includes blood work, physical examination, and various diagnostic tests. The patient is in generally good health with normal findings across most parameters. Some minor areas warrant follow-up monitoring as outlined in this report.

VITAL SIGNS & PHYSICAL EXAMINATION

Parameter	Result	Reference Range	Status
Blood Pressure	128/82 mmHg	<120/80 mmHg	Normal
Heart Rate	72 bpm	60-100 bpm	Normal
Respiratory Rate	16 breaths/min	12-20 breaths/min	Normal
Temperature	37.1°C	36.5-37.5°C	Normal
Body Weight	78 kg	—	—
Height	180 cm	—	—
BMI	24.1 kg/m ²	18.5-24.9	Normal

Parameter	Result	Reference Range	Status
Waist Circumference	88 cm	<102 cm (male)	Normal

Physical Examination Findings:

- General: Patient alert and oriented, no distress
- Skin: Clear, no lesions or abnormalities
- Cardiovascular: Regular rate and rhythm, no murmurs
- Respiratory: Clear bilateral lung fields
- Abdomen: Soft, non-tender, normal bowel sounds
- Extremities: No edema, normal pulses

BLOOD TEST RESULTS

Complete Blood Count (CBC)

Test	Result	Reference Range	Status
White Blood Cell (WBC)	7.2 K/uL	4.5-11.0 K/uL	Normal
Red Blood Cell (RBC)	4.8 M/uL	4.5-5.9 M/uL	Normal
Hemoglobin	14.2 g/dL	13.5-17.5 g/dL	Normal
Hematocrit	42%	38-50%	Normal
Mean Corpuscular Volume (MCV)	88 fL	80-100 fL	Normal
Platelet Count	245 K/uL	150-400 K/uL	Normal

Interpretation: No evidence of anemia, infection, or clotting disorders.