

MEDICAL EVALUATION REPORT - SUMMARY



CANDIDATE / EMPLOYEE IDENTIFICATION					
Civil ID / Passport #	Company ID #	Name		Position	
740652		Sugnanantham J			
Nationality	Age	Sex	Company	Location	
Indian	40 M		Tauk Oman		
EXAMINATION TYPE					
Examination	<input type="checkbox"/> Pre-employment	<input type="checkbox"/> Periodic	<input type="checkbox"/> Exit		

VITAL SIGNS & BODY MEASURES	
Blood Pressure Category:	150/100 - <input type="checkbox"/> Normal <input type="checkbox"/> Prehypertension <input checked="" type="checkbox"/> Hypertension Stage 1 <input type="checkbox"/> Hypertension Stage 2 <input type="checkbox"/> Hypertension Crisis
BMI Category:	26.1 <input type="checkbox"/> Underweight <input checked="" type="checkbox"/> Normal <input checked="" type="checkbox"/> Overweight <input type="checkbox"/> Obese <input type="checkbox"/> Morbid Obesity
Remarks:	

VISUAL TEST	
Visual Acuity Test	RT 6/6 LT 6/6 <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Colour Vision Test	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required
Pre-existing condition:	
Remarks:	

RESPIRATORY SYSTEM	
Spirometry Test	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required
Chest X-Ray	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required
Physical Assessment	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Pre-existing condition:	
Remarks:	

ENT SYSTEM	
Audiometry Test	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required
Otoscopy	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required
Physical Assessment	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Whisper, Weber & Rinne Tests)
Pre-existing condition:	
Remarks:	

CARDIOVASCULAR SYSTEM	
ECG Test	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required
Physical Assessment	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Pre-existing condition:	
Remarks:	

NEUROLOGICAL SYSTEM	
Physical Assessment	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Pre-existing condition:	
Remarks:	

MUSCULOSKELETAL SYSTEM	
Physical Assess.	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Lumbar X-Ray	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required
Pre-existing condition:	
Remarks:	

LABORATORY INVESTIGATIONS	
Lab Tests:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal If abnormal, please specify below: <input type="text"/>
Blood Grouping:	<input type="text"/>
Pre-existing condition:	
Remarks:	

Glucose Level Category	<input type="checkbox"/> Normal 80 - 100 mg/dl <input type="checkbox"/> Pre-diabetic 100 - 125 mg/dl <input type="checkbox"/> Diabetic > 125 mg/dl
Cholesterol Risk Category	<input type="checkbox"/> Low Risk LDL is less 130 mg/dl <input type="checkbox"/> Moderate Risk LDL 130-159 mg/dl <input type="checkbox"/> High Risk LDL >160 mg/dl
Routine Urine Analysis	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required
Stool Analysis	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required

QUESTIONNAIRES	
Medical & Surgical History Questionnaire	Remarks
Respiratory Protection Questionnaire	Remarks
Hearing Conservation Questionnaire	Remarks
Screening Questionnaire	Remarks

Fagerstrom Test - Smoking	<input type="checkbox"/> Non-smoker <input type="checkbox"/> Low dependence <input type="checkbox"/> Low to Mod dependence <input type="checkbox"/> Moderate dependence <input type="checkbox"/> High dependence
CAGE Questionnaire Alcohol Use	<input type="checkbox"/> No use of alcohol <input type="checkbox"/> Screening negative <input type="checkbox"/> Clinically significant
SRO-20 Self-reported Questionnaire	<input type="checkbox"/> No positive answers <input type="checkbox"/> Positive answers Factor I (1 to 6) <input type="checkbox"/> Positive answers Factor II (7 to 12) <input type="checkbox"/> Positive answers Factor III (13 to 18) <input type="checkbox"/> Positive answers Factor IV (17 to 20)

Clinic Doctor Name	License #	Hospital/Clinic	Doctor Signature & Clinic Stamp	Issue Date
DR. ASWATHY RAVI				

DR. ASWATHY RAVI
 General Practitioner
 MOH Lic. No: 20556
 nmc specialty hospital, Al Hail



FITNESS TO WORK CERTIFICATE



EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name		Position
741047652		Sughanantham J		
Nationality	Age	Sex	Company	Location
Indian	40	M	Tauk Oman	

EXAMINATION TYPE					
<input type="checkbox"/>	Pre-employment Examination (PRE)	<input type="checkbox"/>	Periodic Medical Examination (PME)	<input type="checkbox"/>	Post-absence Examination
<input type="checkbox"/>	Change of Position Examination	<input type="checkbox"/>	Exit Examination	<input type="checkbox"/>	Critical Activities Examination
<input type="checkbox"/>	Emergency Response Team	<input type="checkbox"/>	Traveling Examination		

Medical Suitability for Work	
Medical Suitability for Work	<input checked="" type="checkbox"/> Fit to work <input type="checkbox"/> Fit with following restrictions <input type="checkbox"/> Pending Fitness <input type="checkbox"/> Not fit to work

DR. MAHDI MAHMOUD KARMI
 General Practitioner
 MOH Lic. No: 23169
 nmc speciality hospital, Al Hall

05, 10, 2024

FIT

Restrictions

<input type="checkbox"/>	Working at height	<input type="checkbox"/>	Pulling, pushing or carrying weight
<input type="checkbox"/>	Working in confined space	<input type="checkbox"/>	Ascend/descend ladders and stairs
<input type="checkbox"/>	Working with electricity	<input type="checkbox"/>	Walking or standing for long distance/period
<input type="checkbox"/>	Working in extreme heat	<input type="checkbox"/>	Repetitive movements
<input type="checkbox"/>	Working near rotating machinery	<input type="checkbox"/>	Operating cargo machinery
<input type="checkbox"/>	Use of respirator	<input type="checkbox"/>	Emergency response duty
<input type="checkbox"/>	Driving vehicle	<input type="checkbox"/>	Handling chemical products
<input type="checkbox"/>	Flying	Other, specify	

New Position	New Function	New Department
NA	NA	NA

Examination Date	Exams Performed
05.10.2024	

Medical Review Date	Employee Signature
	J: [Signature]

Doctor Name	Medical License	Hospital	Medical Coordinator Signature

DR. ASWATHY RAVI
 General Practitioner
 MOH Lic. No: 24756
 nmc speciality hospital, Al Hall



MEDICAL & SURGICAL HISTORY QUESTIONNAIRE



CANDIDATE / EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name		Position
F4047652		Sughanantham J		
Nationality	Age	Sex	Company	Location
Indo	40	M	Tack Oman	

PERSONAL HEALTH HISTORY

Have you ever, or do you currently suffer from any of the following?

Disorders of the heart or circulation i.e. chest pain, heart murmurs.	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Skin disorders e.g. severe acne, dermatitis, eczema or allergy	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Ear, nose or throat problems	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Palpitations i.e. being aware of the heart beats	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Allergies e.g. dust, medication, bee stings	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Lung disease e.g. bronchitis, asthma, dyspnea, T.B	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Kidney or bladder diseases e.g. recurrent infection, renal stones	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Phlegm productions or tight chest	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Sexually transmitted disease	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Blackouts, dizziness, fainting, memory loss, unconsciousness (vertigo/nyctopsia)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Is your eyesight satisfactory	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Nervous disorder, or emotional breakdown, depression, anxiety	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Is your hearing satisfactory	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy / Seizures	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Do you wear glasses or contact lenses	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Recurrent headaches or migraines	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Do you have color blindness	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Any sleep problems	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Do you have any phobia from working at heights	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Foot deformities or problems	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Do you have any phobia from working at confined spaces	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Muscle problems e.g. weakness of your limbs or twitchy muscles	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Experienced weight loss or gain > 5kg over the past year	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Joint problems, e.g. plantar warts, joint pain, or swelling	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Informed about being overweight or obese	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Problems with limb, neck or spine mobility	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Treated for malaria	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Experienced back problem, arthritis, slipped disc	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Treated for depression, stress	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Disorders of the digestive tract e.g. ulcers, recurrent diarrhea, gall stones	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Treated for substance abuse	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Rectal bleeding, jaundice	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Received counseling or treatment for HIV/AIDS	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Diabetes or any other glandular diseases	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Received counseling or treatment for Hepatitis	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Cancer, growth or tumor of any kind	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Anemia, especially Sickle Cell Disease or Sickle Cell Trait or Thalassemia	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Frequent headache	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	G6PD (Glucose)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Pain in neck or back or hands or legs	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Any other diseases not mentioned in the above list?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Have you visited a doctor in the last year? Yes No

Are you taking any medication at present? Yes No

Are you pregnant? Yes NA

Date: 5/10/24

List any previous injuries or operations

Previous injuries or operations	Date
None	

Candidate/Employee Signature:



SCREENING QUESTIONNAIRE



CANDIDATE / EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name	Position	
Indian → 7404765		Singhanantham J		
Nationality	Age	Sex	Company	Location
Indian	40	M	Touck Oman	

FAGERSTROM TEST

Do you smoke? Yes No *If YES, Please answer the following:*

How soon after waking up do you smoke your first cigarette? >60min 31-60min 6-30min < 5 minutes

Do you find it difficult to avoid smoking where it is forbidden, such as work places, cinemas, shopping etc.? Yes No

What's the most difficult cigarette to quit or not to smoke Anyone The first in the morning

How many cigarettes do you smoke per day <10 11-20 21-30 >31

Do you smoke more frequently the first hours of the day than the rest of the day Yes No

Do you smoke even when you're sick and have to stay in the bed most part of the day Yes No

CAGE QUESTIONNAIRE

Do you drink alcohol? Yes No *If YES, Please answer the following:*

Did you ever feel that you should decrease the amount of drinks or cut down (stop) drinking? Yes No

Do people bother you because they criticize the way you drink? Yes No

Do you feel guilty or upset with yourself with the way you use to drink Yes No

Do you drink in the morning to feel less nervous or decrease the hang over Yes No

Have you had any problems related to alcohol Yes No

Did you drink in the last 24 hours Yes No

FATIGUE QUESTIONNAIRE

Have you noticed that you are feeling tired recently? Yes No

Have you been feeling a lack of energy Yes No *If YES, Please answer the following:*

For how many days did you feel tired or with lack of energy in the last week 1 day 2 days 3 days > 3 days

Did you feel tired or with lack of energy for more than 3 hrs in some days last week? 1 hour 2 hours 3 hours > 3 hours

Did you feel so tired that you had to make some effort to do things last week Yes No

Did you feel tired or with lack of energy doing things you like last week Yes No

SELF-REPORTING QUESTIONNAIRE (SRQ-20) *None*

1. Do you have trouble thinking clearly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	11. Is your digestion not good?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you find it hard to like your daily work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	12. Do you have unpleasant sensations in your stomach?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Do you find difficult taking decisions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	13. Do you get scared easily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Is your daily work suffering?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	14. Do you feel nervous, tense or worried?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Do you feel tired all the time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	15. Do you feel unhappy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Are you easily tired?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	16. Do you cry more than usual?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Do you have frequent headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	17. Has the thought of ending your life been on your mind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Do you feel lack of hunger?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	18. Do you find it difficult to perform your work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Do you sleep badly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	19. Have you lost interest in things?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Do your hands tremble?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20. Do you feel you're worthless?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Date: 05/10/24

Candidate/Employee Signature: *[Signature]* No: 1000137
 Substitute of Origin

RECEPTION
 nmc specialty hospital, Al Hail

RESPIRATORY PROTECTION QUESTIONNAIRE



CANDIDATE / EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name		Position
74047652		Suganthan J		
Nationality	Age	Sex	Company	Location
Indian	40	M	Tauk Omar	

RESPIRATORY PROTECTION MEDICAL EVALUATION QUESTIONNAIRE - OSHA

Do you use a respirator? YES NO What type: Disposable mask Cartridge Mask SCBA

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? YES NO

2. Have you ever had any of the following conditions? *None*

<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	a. Seizures	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. Trouble smelling odors	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	e. Claustrophobia (fear of closed in places)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. Diabetes (sugar disease)	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	d. Allergic reactions that interfere with your breathing		

3. Have you ever had any of the following pulmonary or lung problems? *None*

<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	a. Asbestosis	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	e. Pneumonia	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	i. Broken ribs
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. Asthma	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	f. Tuberculosis	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	j. Pneumothorax (collapsed lung)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. Chronic bronchitis	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	g. Silicosis	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	k. Any chest injuries or surgeries
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	d. Emphysema	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	h. Lung cancer	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	l. Any other lung problem that you have been told about

4. Do you currently have any of the following symptoms of pulmonary or lung illness? *None*

<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	a. Shortness of breath	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	h. Coughing that wakes you early in the morning
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	i. Coughing that occurs mostly when you are lying down
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	j. Coughing up blood in the last month
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	k. Wheezing
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	e. Shortness of breath when washing or dressing yourself	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	l. Wheezing that interferes with your job
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	f. Shortness of breath that interferes with your job	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	m. Chest pain when you breathe deeply
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	n. Any other symptoms that you think may be related to lung problems

5. Have you ever had any of the following cardiovascular or heart problems? *None*

<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	a. Heart attack	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	e. Swelling in your legs or feet (not caused by walking)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. Stroke	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	f. Heart arrhythmia
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. Angina	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	g. High blood pressure
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	d. Heart failure	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	h. Any other heart problems that you've been told about

6. Have you ever had any of the following cardiovascular or heart symptoms? *None*

<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	a. Frequent pain or tightness in your chest	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	e. Heartburn or indigestion that is not related to eating
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. Pain or tightness in your chest during physical activity	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	f. Any other symptoms that you think might be related to heart
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. Pain or tightness in your chest that interferes with your job		
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	d. In the past two years, have you noticed your heart skipping or missing a beat		

7. Do you currently take medication for any of the following problems? *None*

<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	a. Breathing or lung problems	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. Blood pressure
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. Heart trouble	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	d. Seizures (fits)

8. If you've used a respirator, have you ever had any of the following problems?

<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	a. Eye irritation	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	d. General weakness or fatigue
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. Skin allergies or rashes	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	e. Any other problem that interferes with your use of a respirator
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. Anxiety		

Date: 05/10/24

Candidate/Employee Signature

J:



HEARING CONSERVATION QUESTIONNAIRE



CANDIDATE / EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name		Position
74047652		Sugantham J		
Nationality	Age	Sex	Company	Location
Indian	40	M	Truck Owner	

HEARING CONSERVATION MEDICAL EVALUATION QUESTIONNAIRE - OSHA

Do you use hearing protection? YES NO What type? Earplugs Ear Muffs Double HP

1 - Have you been out of noise for the past 14-16 hours? YES NO
 If NO, did you use hearing protection while in the noise? YES NO

2 - Check ALL of the following activities that you have done or do: **None**

<input type="checkbox"/> Hunting	<input type="checkbox"/> Car races	<input type="checkbox"/> Skew shooting	<input type="checkbox"/> Woodwork	<input type="checkbox"/> Target shooting
<input type="checkbox"/> Power tools	<input type="checkbox"/> Mower	<input type="checkbox"/> Concerts / Band	<input type="checkbox"/> Welding	<input type="checkbox"/> Air compressor
<input type="checkbox"/> Construction	<input type="checkbox"/> Scuba diving	<input type="checkbox"/> Tractor (open or closed cab)		

Have you ALWAYS used hearing protection when participating in the above activities? YES NO

3 - Check ALL that you have experienced: **None**

<input type="checkbox"/> Ear Fullness	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Ear Surgery	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Earwax buildup	<input type="checkbox"/> Intravenous Antibiotics	<input type="checkbox"/> Hole in the Eardrum
<input type="checkbox"/> Ear Drainage	<input type="checkbox"/> Dizziness			

4 - Check ALL that you have had/suffered from: **None**

<input type="checkbox"/> Meningitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Measles	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Mumps	<input type="checkbox"/> Chronic ear infections
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Renal Failure	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Previous surgery	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Trauma to head/ ear canal / tympanic membrane	

5 - Check ALL that you are currently suffering from: **None**

<input type="checkbox"/> Otosclerosis	<input type="checkbox"/> Colds/Flu	<input type="checkbox"/> Ear infection	<input type="checkbox"/> Allergic rhinitis
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6 - Do you have documented Hearing Loss? YES NO
 If Yes: Which Ear(s)? Right Ear Left Ear Both Ear Who performed your hearing test?

7 - Have you EVER worn Hearing Aids? YES NO
 If Yes: Which Ear(s) Right Ear Left Ear Both Ear
 What Size? Behind-the-ear In-the-ear In-the-canal Completely-in-the-canal
 What Type? Analog Digital
 Who fit your hearing aids? Licensed Audiologist Hearing Aid Dealer Don't know
 When did you receive your hearing aids?

8 - Have you ever served in the military? YES NO
 If yes, check division Army Navy Air Force Marines National Guard Date: / /
 Do you have medical disability through the Veterans Administration (VA) for hearing loss or tinnitus? YES NO
 If yes, how much? _____% What is your TOTAL VA disability? _____%

9 - Are you currently using any medication? YES NO Which one?

10 - What kind of transport do you regularly use? Car Bus Motorcycle Walking

Date: 5/10/24

Candidate/Employee Signature: J. Sugantham

PHYSICAL ASSESSMENT FORM



CANDIDATE / EMPLOYEE IDENTIFICATION					
Civil ID / Passport #	Company ID #	Name		Position	
AU041652		Syghananaham J			
Nationality	Age	Sex	Company	Location	
Indian	40 M	M	Touck Oman		

VITAL SIGNS					
Height	176 cm	Weight	81 kg	BMI	26.1
Pulse	78 /min	Blood Pressure	140/90 mmHg		

VISUAL SYSTEM					
Right Uncorrected	Left Uncorrected	Right Corrected	Left Corrected	Right Uncorrected	Left Corrected
6/6	6/6	-	-	6/6	
Colour Vision Test (Ishihara)	# of Plates passed	Inform the Plates # failed	Normal / Abnormal	Visual Field Test	Normal / Abnormal
			Normal		Normal

RESPIRATORY SYSTEM					
[1] Spirometry Test	Smoking Status: <input type="checkbox"/> Never <input type="checkbox"/> Ever Used <input checked="" type="checkbox"/> Current				
Diagnosis:	<input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Other				
Acceptability Criteria	Repeatability Criteria				
<input type="checkbox"/> Free from artifacts	<input type="checkbox"/> >3 acceptable curves FEV1 values AND FVC values within 0.15L (150 ml)				
<input type="checkbox"/> Good start	<input type="checkbox"/> Total of THREE to EIGHT tests performed				
<input type="checkbox"/> Satisfactory exhalation	<input type="checkbox"/> The patient CAN NOT or SHOULD NOT continue				
<input type="checkbox"/> NOT satisfactory					

[2] Chest Shape and Movement					
Normal	if abnormal, describe below:				
Abnormal					
Not Examined					

[3] Air Entry in Both Lungs					
Normal	if abnormal, describe below:				
Abnormal					
Not Examined					

[4] ENT SYSTEM					
[1] Otoscopy	Ear Canal Collapse				[2] Hearing Test
Right	Left	Right	Left	Whisper Test	Normal / Abnormal / Not Exam
<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Rinne Test	Normal / Abnormal / Not Exam
<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Retracted	<input type="checkbox"/> Retracted	Weber Test	Normal / Abnormal / Not Exam
<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Bulging	<input type="checkbox"/> Bulging	Adrometry Done	Yes / No
<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	Hearing Questionnaire verified	Yes / No

Drainage	Right	Left	Eardrum Position	Right	Left
<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Normal	<input checked="" type="checkbox"/> Normal	<input checked="" type="checkbox"/> Normal
<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Unknown	<input type="checkbox"/> Retracted	<input type="checkbox"/> Considerable	<input type="checkbox"/> Considerable
<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Unknown	<input type="checkbox"/> Bulging	<input type="checkbox"/> Mid	<input type="checkbox"/> Not Exam
<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam
Perforation	Right	Left	Eardrum Vascularity	Right	Left
<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Normal	<input checked="" type="checkbox"/> Normal	<input checked="" type="checkbox"/> Normal
<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Considerable	<input type="checkbox"/> Mid	<input type="checkbox"/> Not Exam
<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam
Cerumen	Right	Left	Audiologist Name:	Signature:	
<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> None			
<input type="checkbox"/> Some	<input type="checkbox"/> A lot	<input type="checkbox"/> A lot			
<input type="checkbox"/> Not Exam	<input type="checkbox"/> Impacted	<input type="checkbox"/> Impacted			
<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam			

DR. ASWATHY RAVI
General Practitioner
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nmc specialty hospital, Al Hail

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PHYSICAL ASSESSMENT FORM



ENT SYSTEM			
[2] Nose Assessment	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[3] Throat Assessment	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
CARDIOVASCULAR SYSTEM			
[1] Heart Sounds	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[2] Heart Murmurs	<input checked="" type="checkbox"/> Present	<input type="checkbox"/> Absent	If present, describe below:
[3] Peripheral Pulses	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[4] Peripheral Veins	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
NEUROLOGICAL SYSTEM			
[1] Mental Status	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[2] Cranial Nerves	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[3] Motor System	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[4] Reflexes	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[5] Sensory System	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[6] Coordination, Station, Gait	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
MUSCULOSKELETAL SYSTEM			
[1] Hand and Wrist	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[2] Elbow and Shoulder	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[3] Hip	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[4] Knee	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[5] Foot and Ankle	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[6] Spine and Back	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
OTHER			
[1] Skin, Extremities	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[2] Head & Neck	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[3] Mouth and Teeth	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[4] Hernial Orifices	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[5] Abdominal Organs	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:
[6] Lymph Nodes	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, describe below:

Date of Examination: 05.10.2024 Physician Name: _____

DR. ASWATHY RAVI
 General Practitioner
 MGH Lic. No. 20556
 nmc specialty hospital, Al Hall



[Handwritten Signature]

DEPARTMENT OF LABORATORY MEDICINE

File No: 50126460	Report No: 0133198
Name: SUGHANANTHAM JUSTIN	Sample Date: 05/10/2024 Time: 9:04
Address:	Received By:
Gender: M Age: 40 Y Nationality: INDIAN	Received Date: Time:
GSM No.: 78217989 ID Card No.: 74047652	Report Date: 05/10/2024 Time: 14:34
Ref. By: DR ASWATHY RAVI	Bill No: 0328465 Bill Date: 05/10/2024

INVESTIGATION	RESULT	REFERENCE RANGE
OQ FTW PACKAGE-1 (Below 49 yrs)		
COMPLETE BLOOD COUNT		
TOTAL WBC COUNT	9.49 x 10 ³ / μ L	4.00-11.00 x 10 ³ / μ L
DIFFERENTIAL COUNT		
NEUTROPHIL (%)	58.48 %	40-75%
LYMPHOCYTE (%)	32.16 %	20-45%
MONOCYTE (%)	5.69 %	2-8%
EOSINOPHIL (%)	2.73 %	1-6%
BASOPHIL (%)	0.95 %	0-1%
HAEMOGLOBIN	15.78 gm/dl	Male : 13 -18 gm/dl Female:11-15 gm /dl childrens upto 1year-11.0 - 13.0 gm /dl upto12years-11.5 - 14.5 gm /dl cord blood:13 -19.5 gm /dl
RBC COUNT	5.27 million/cu	Male :4.5-6.5 million/cu Female:3.9-5.5 million/cu
PLATELET COUNT	274.60 x 10 ³ / μ L	150 - 400 x 10 ³ / μ L
HEMATOCRIT	48.62 %	Male :42 - 52% Female:37- 47%
MCV	92.19 fl	76 - 96 fl
MCH	29.92 pg	27 - 33 pg
MCHC	32.45 gm/dl	32 - 36 gm/dl
URINE ROUTINE		
URINE BIOCHEMISTRY		
URINE GLUCOSE	NEGATIVE	NEGATIVE

Verified By:



11011

Lab Technologist

Approved By:

Specialist Pathologist



MOH License No:
Electronically signed at: 10/5/2024 2:35:00

Printed at: 05/10/2024 4:04:49 PM

Page : 1 of 4

DEPARTMENT OF LABORATORY MEDICINE

File No: 50126460	Report No: 0133198
Name: SUGHANANTHAM JUSTIN	Sample Date: 05/10/2024 Time: 9:04
Address:	Received By:
Gender: M Age: 40 Y Nationality: INDIAN	Received Date: Time:
GSM No.: 78217989 ID Card No.: 74047652	Report Date: 05/10/2024 Time: 14:34
Ref. By: DR ASWATHY RAVI	Bill No: 0328465 Bill Date: 05/10/2024

INVESTIGATION	RESULT	REFERENCE RANGE
URINE PROTEIN	NEGATIVE	NEGATIVE
URINE KETONE	NEGATIVE	NEGATIVE
URINE BILIRUBIN	NEGATIVE	NEGATIVE
NITRITE	NEGATIVE	NEGATIVE
URINE PH	6.0	4.6-8.0
SPECIFIC GRAVITY	1.010	1.010-1.030
BLOOD	NEGATIVE	NEGATIVE
UROBILINOGEN	NORMAL	NORMAL
URINE MACROSCOPY		
COLOUR	PALE YELLOW	
APPEARANCE	CLEAR	
URINE MICROSCOPY		
RBC	NIL /hpf	0-3
PUSCELLS	1-3 /hpf	0-6
EPITHELIAL CELLS	1-2 /hpf	NIL
CRYSTAL	NIL /hpf	NIL
CAST	NIL /hpf	NIL
BACTERIA	NIL	NIL
MUCOUS THREAD	NIL	NIL
FASTING BLOOD SUGAR	4.60 mmol/L	4.11 - 6.05 mmol/L
BLOOD GROUP & RH TYPING	" B " Rh POSITIVE	

Confirmation of the Newborn's blood group is indicated when the "A" and "B" antigen expression and the isoagglutinins are fully developed (2-4 years).

Verified By:

Approved By:



11011

Lab Technologist

Specialist Pathologist

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Page : 2 of 4



DEPARTMENT OF LABORATORY MEDICINE

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Ref. By: DR ASWATHY RAVI	Bill No: 0328465 Bill Date: 05/10/2024

INVESTIGATION	RESULT	REFERENCE RANGE
LIPID PROFILE		
TOTAL CHOLESTEROL	4.57 mmol/L	< 5.18 mmol/L
HDL	1.37 mmol/L	>1.5 mmol/L
TRIGLYCERIDES	0.99 mmol/L	Desirable : <2.083 mmol/L Boderline high : 2.83 - 5.67 mmol/L Hypertriglyceridemia >5.65 mmol/L
LDL	2.80 mmol/L	< 2.6 mmol/L
VLDL	0.45 mmol/L	0.128-0.645mmol/L
LIVER FUNCTION TEST		
TOTAL BILIRUBIN	16.40 µ mol/L	Adults:- up to 21 µ mol/L, Children >1 month - up to 17 µ mol/L, Neonates :- 1.7 - 180 µmol/L
DIRECT BILIRUBIN	4.90 µ mol/L	Adults :- 0 - 5.0 µ mol/L, Neonates:- 0-10 µ mol/L,
TOTAL PROTIEEN	76.00 g/L	Adults : 66 - 87 g/L
ALBUMIN	47.30 g/L	39.7 - 49.4 g/L
Globulin	28.7 g/L	23-35g/L
SGOT (AST)	36.90 U/L	MALE : up to 40 U/L, FEMALE : up to 32 U/L
SGPT (ALT)	50.50 U/L	MALE : up to 41 U/L, FEMALE : up to 33 U/L
ALKPO4 (ALP)	148.00 U/L	Adults: MALES: 40 - 129 U/L, FEMALES: 35 - 104 U/L
Gamma GT (GGT)	70.00 U/L	MALE- 8 - 61 U/L, FEMALE- 5 - 36 U/L

Verified By:

Approved By:



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Printed at: 05/10/2024 4:04:49 PM

Page : 3 of 4



DEPARTMENT OF LABORATORY MEDICINE

File No: 50126460	Report No: 0133198
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Gender: M Age: 40 Y Nationality: INDIAN	Received Date: Time:
GSM No.: 78217989 ID Card No.: 74047652	Report Date: 05/10/2024 Time: 14:34
Ref. By: DR ASWATHY RAVI	Bill No: 0328465 Bill Date: 05/10/2024

INVESTIGATION	RESULT	REFERENCE RANGE
RENAL FUNCTION TEST		
URIC ACID	451.00 µ mol/L	MALE: 202.3 - 416.5 µ mol/L, FEMALE: 142.8 - 339.2 µ mol/L
CREATININE	87.00 µ mol/L	Adults: MALE: 62 - 106 µ mol/L FEMALE: 44 - 80 µ mol/L
UREA	4.40 mmol/L	2.76 - 8.07 mmol/L
SICKLE CELL	NEGATIVE	
Method : Solubility test (If Positive , Hb Electrophoresis / HPLC to be done to confirm Sickle cell anaemia / Trait).		

Verified By:

Approved By:



11011

Lab Technologist

Specialist Pathologist

MOH License No:
Electronically signed at: 10/5/2024 2:35:00



Printed at: 05/10/2024 4:04:49 PM

Page: 4 of 4

AUDIOMETRY REPORT

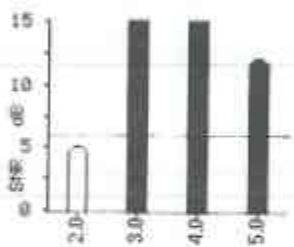
Name of the Patient Sugnanathan Justin

Age 40y Sex M MRN 50126460 Date of Test 05/10/2024

U107.05
05-OCT-24 10:12
DP 2s 2 sec avg
SN: G11005649 G12014595

NAME: _____

Left: Pass

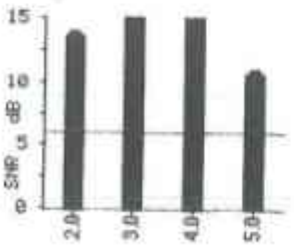


F2	L1	L2	DP	NF	SNR	
2.0	65	55	-7	-12	5	P
3.0	65	55	-2	-18	20	P
4.0	65	55	-1	-20	19	P
5.0	65	55	-8	-20	12	P

U107.05
05-OCT-24 10:12
DP 2s 2 sec avg
SN: G11005649 G12014595

NAME: _____

Right: Pass



F2	L1	L2	DP	NF	SNR	
2.0	65	55	-4	-18	14	P
3.0	65	55	-2	-18	20	P
4.0	65	55	-1	-17	17	P
5.0	65	55	-9	-20	11	P

RECEPTION

RECEPTION

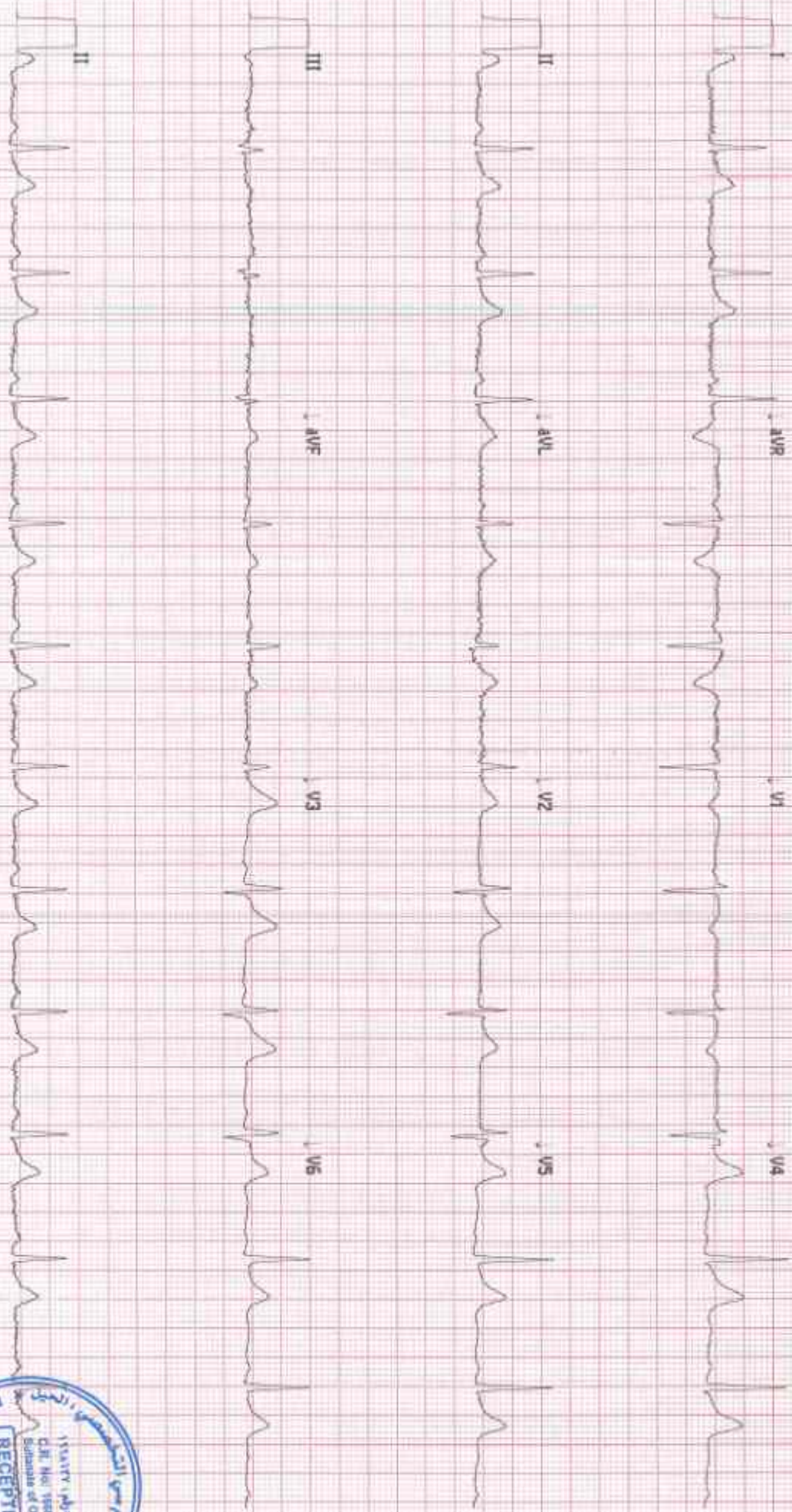
Signature of the Technician

NMCOMAN/DOC/NSG775

LU: ZUIC98BU
DOB:
40yr, Male

Vent rate: 70 BPM
PR int 146 ms
QRS dur: 90 ms
QT/QTc: 386/407 ms
P-R-T axes: 39 28 29

SINUS RHYTHM
POSSIBLE RIGHT VENTRICULAR CONDUCTION DELAY (RSR (R) IN V1/V2)
BORDERLINE ECG
UNCONFIRMED REPORT



Atalograph[®]

Pulmonary Function Report

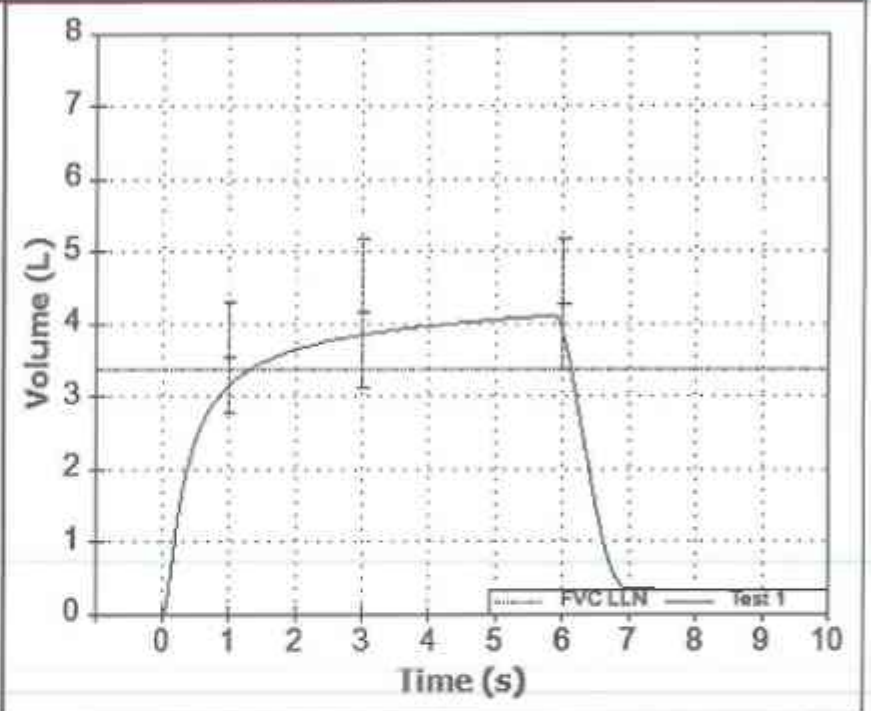
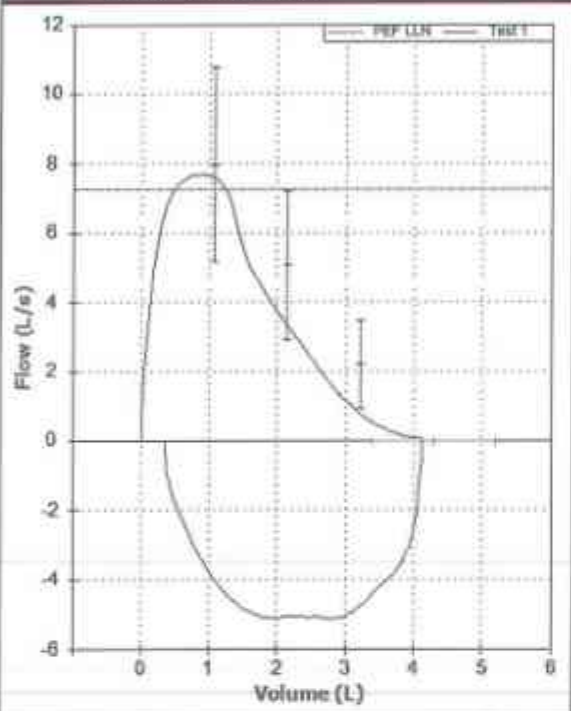
Subject Information

ID:	2024279_095139821	Alternate ID:	50126460	Middle Name:	
Last Name:	Justin	First Name:	Sughanantham	Date of Birth:	23/07/1984
Population:	Asian	Gender:	Male	Weight:	78.0 kg
Age:	40	Height:	176 cm		
BMI:	25.2	Smoking:	Non Smoker		

Test Session Information

Test Date:	05/10/2024 09:58	Device:	ALPHA Touch	Serial Number:	32166
No. of Tests:	4	Accuracy Chk:	30/05/2019 15:42	User:	Administrator
Pred. Values:	ERS 93	Pred. Factor:	90%	Posture:	Sitting

Flow/Volume Graph
Volume/Time Graph



Results:

Parameter	Pred	LLN	Best	% Pred.	Z-Score
FVC (L)	4.28	3.38	4.11	96	-0.31
FEV1 (L)	3.53	2.77	3.20	91	-0.71
FEV1 Ratio	0.80	0.68	0.78	98	-0.27
FEV6 (L)	4.28	3.38	4.11	96	-0.31
PEF (L/min)	554	436	506	91	-0.67
FEF25-75 (L/s)	4.39	2.68	2.80	64	-1.52

Values at BTPS, *Below lower limit of normality (LLN)

Session Quality and Repeatability Information

FVC Session Grade	FVC Rep:	FEV1 Rep:	Slow Start of test	End of test criteria not achieved	Cough detected in 1st second
C	0.41 L (10.0%)	0.23 L (7.2%)	0 blow(s)	2 blow(s)	0 blow(s)

Computer Suggested Interpretation

Computer interpretations cannot be relied upon for diagnosis. Normal ventilatory function.

Reference Pictogram

FVC	○	○	○	○	○	○	○
FEV1	○	○	○	○	○	○	○
FEV1 Ratio	○	○	○	○	○	○	○

LLN Reference



Medscce

News & Perspective Drugs & Diseases CME & Education Video Decision Point

Drugs & Diseases > Calculators

Calculator	About	References
Framingham Risk Score (2008)		
Questions		
1. Gender?		Male
2. Age?		40-44
3. Total Cholesterol?		4.14-5.15 mmol/L
4. HDL?		1.30-1.55 mmol/L
5. Systolic Blood Pressure?		150-159 mmHg
6. On Medication for Hypertension?		No
7. Smoker?		No
8. Diabetic?		No
9. Known Vascular Disease (CAD, PVD, S...		No

About

The FRS estimates the 10 year risk of manifesting clinical CVD (CAD, Stroke, PVD, CHF, cardiac death). Although not examined in the 2008 model, it is common practice to double the FRS if there is a FHx of premature CAD in a 1st degree relative (men <55y, women <65y).

*The risk stratification tool for the ESC is the SCORE system which estimates 10y risk of CVD death. Patients with a 10y risk of CVD death $\geq 5\%$ are considered high risk. The lipid guidelines recognize risk equivalents as a distinct category that warrant immediate treatment. For patients with an ESC SCORE $\geq 5\%$ a 3 month trial of lifestyle measures is a reasonable starting point. If after 3 months the lipids remain above moderate risk targets and the SCORE remains $\geq 5\%$ then intensive therapy to reach high risk targets is recommended.

References

Ralph B. D'Agostino, Sr, Ramachandran S. Vasan, Michael J. Pencina, Philip A. Wolf, Mark Cobain, Joseph M. Massaro and William B. Kannel.

General cardiovascular risk profile for use in primary care: the Framingham Heart Study.

Circulation 2008 February 12, 117 (6): 743-53

McPherson R et al.

Canadian Cardiovascular Society position statement—recommendations for the diagnosis and treatment of dyslipidemia and

Default Units v

Results

Copy Results

Estimated 10-year Global CVD Risk

5.6%

Risk Category

Low Risk

Estimated Vascular Age

45 Years

Treatment Guidelines

ATP-III (2004)

Treatment targets

LDL <160 mg/dL (<4.14 mmol/L)

Non-HDL <190 mg/dL (<4.93 mmol/L)

CCS (2009)

Initiate Pharmacotherapy if

LDL >5 mmol/L (>193 mg/dL)

TChol/HDL-C >6 mmol/L (>231 mg/dL)

Treatment Targets

$\geq 50\%$ decrease in LDL-C

ESC (2007, see Info for more)

Treatment Targets

LDL <3 mmol/L (<120 mg/dL)

TChol <5 mmol/L (<194 mg/dL)

Created by QXMD



