

MEDICAL EVALUATION REPORT - SUMMARY

CANDIDATE / EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name		Position
69582768		NARSIMLU WODARNA		
Nationality	Age	Sex	Company	Location
INDIAN	60y			
EXAMINATION TYPE				
Examination	<input type="checkbox"/> Pre-employment	<input type="checkbox"/> Periodic	<input type="checkbox"/> COE	
VITAL SIGNS & BODY MEASURES				
Blood Pressure Category	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Prehypertension	<input type="checkbox"/> Hypertension Stage 1	<input type="checkbox"/> Hypertension Stage 2
BMI Category	<input type="checkbox"/> Underweight	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Overweight	<input type="checkbox"/> Obese
Remarks:				
VISUAL TEST				
Visual Acuity Test	RT	LT	Visual Field Test	<input checked="" type="checkbox"/> Normal
Color Vision Test	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Stereoscopic Vision Test	<input type="checkbox"/> Normal
Pre-existing condition:				
Remarks:				
RESPIRATORY SYSTEM				
Spirometry Test	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Chest X-Ray	<input type="checkbox"/> Normal
Pre-existing condition:			Physical Assessment	<input checked="" type="checkbox"/> Normal
Remarks:				
ENT SYSTEM				
Audiometry Test	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Otology	<input checked="" type="checkbox"/> Normal
Pre-existing condition:			Physical Assessment	<input checked="" type="checkbox"/> Normal
Remarks:				
CARDIOVASCULAR SYSTEM				
ECG Test	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Physical Assessment	<input checked="" type="checkbox"/> Normal
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
Pre-existing condition:				
Remarks:				
LABORATORY INVESTIGATIONS				
Lab Tests:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, please specify below	
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 > 126 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	
QUESTIONNAIRES				
Medical & Surgical History Questionnaire	Remarks			
Respiratory Protection Questionnaire	Remarks			
Hearing Conservation Questionnaire	Remarks			
Screening Questionnaire	Remarks			
Fagerstrom Test - Smoking	<input checked="" type="checkbox"/> Non-smoker	<input type="checkbox"/> Low dependence	<input type="checkbox"/> Low to Mod dependence	<input type="checkbox"/> Moderate dependence
CAOE Questionnaire Alcohol Use	<input checked="" type="checkbox"/> No use of alcohol	<input type="checkbox"/> Screening negative	<input type="checkbox"/> Clinically significant	
BRO-20 Self-reported Questionnaire	<input type="checkbox"/> No positive answers	<input type="checkbox"/> Positive answers Factor I (1 to 5)	<input type="checkbox"/> Positive answers Factor II (7 to 12)	
	<input type="checkbox"/> Positive answers Factor III (13 to 16)	<input type="checkbox"/> Positive answers Factor IV (17 to 20)		
Clinic Doctor Name	License #	Hospital/Practise	Doctor Signature & Print Name	Issue Date
D. K. Saha			DR. SAMIKANTA MOHAPATRA Specialty Hospital, AIIMS	



DR. SAMIKANTA MOHAPATRA
Specialty Hospital, AIIMS
C.H. No. 1242/11
AIIMS

SCREENING QUESTIONNAIRE



CANDIDATE / EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name		Position
64572768		NARSIMLU WOODSANA		
Nationality	Age	Sex	Company	Location
INDIAN	60Y	M		

FAGERSTROM TEST				
Do you smoke?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If YES, Please answer the following:	
How soon after waking up do you smoke your first cigarette?	<input type="checkbox"/> >60min	<input type="checkbox"/> 31-60min	<input type="checkbox"/> 6-30min	<input type="checkbox"/> < 6 minutes
Do you find it difficult to avoid smoking where is forbidden, such as work places, streets, shopping etc.?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
What's the most difficult cigarette to quit or not to smoke	<input type="checkbox"/> Anytime	<input type="checkbox"/> The first in the morning		
How many cigarettes do you smoke per day	<input type="checkbox"/> <10	<input type="checkbox"/> 11-20	<input type="checkbox"/> 21-30	<input type="checkbox"/> >31
Do you smoke more frequently the first hours of the day than the rest of the day	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Do you smoke even when you're sick and have to stay in the bed most part of the day	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

CAGE QUESTIONNAIRE				
Do you drink alcohol?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If YES, Please answer the following:	
Did you ever feel that you should decrease the amount of drinks or cut down (etc) drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Do people bother you because they criticize the way you drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Do you feel guilty or upset with yourself with the way you use to drink.	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Do you drink in the morning to feel less nervous or decrease the hang over	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Have you had any problems related to alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Did you drink in the last 24 hours	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

FATIGUE QUESTIONNAIRE				
Have you noticed that you are feeling tired recently	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		
Have you been feeling a lack of energy	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If YES, Please answer the following:	
For how many days did you feel tired or with lack of energy in the last week	<input type="checkbox"/> 1 day	<input type="checkbox"/> 2 days	<input type="checkbox"/> 3 days	<input type="checkbox"/> > 3 days
Did you feel tired or with lack of energy for more than 2 hrs in some days last week?	<input type="checkbox"/> 1 hour	<input type="checkbox"/> 2 hours	<input type="checkbox"/> 3 hours	<input type="checkbox"/> > 3 hours
Did you feel so tired that you had to make some effort to do things last week	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Did you feel tired or with lack of energy doing things you like last week	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

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

Date: 5/3/26

DR. NARSIMLU WOODSANA
 General Practitioner
 1001 10th Street, Suite 101
 1001 10th Street, Al Hill

C.R. No. 12272
 Registration
 Signature
 Dr. Narsimlu Woodsana

RESPIRATORY PROTECTION QUESTIONNAIRE



CANDIDATE / EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name		Position
64582762		NARSIMLU WOOSANNA		
Nationality	Age	Sex	Company	Location
INDIAN	60Y	M		

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?

YES NO a. Scurvy YES NO c. Trouble smelling odors YES NO e. Claustrophobia (fear of closed in spaces)
 YES NO b. Diabetes (sugar disease) YES NO d. Allergic reactions that interfere with your breathing

3. Have you ever had any of the following pulmonary or lung problems?

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

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

YES NO a. Shortness of breath YES NO h. Coughing that wakes you early in the morning
 YES NO b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline YES NO i. Coughing that occurs mostly when you are lying down
 YES NO c. Shortness of breath when walking with other people at an ordinary pace on level ground YES NO j. Coughing up blood in the last month
 YES NO d. Have to stop for breath when walking at your own pace on level ground YES NO k. Wheezing
 YES NO e. Shortness of breath when washing or dressing yourself YES NO l. Wheezing that interferes with your job
 YES NO f. Shortness of breath that interferes with your job YES NO m. Chest pain when you breathe deeply
 YES NO g. Coughing that produces phlegm (thick sputum) YES 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?

YES NO a. Heart attack YES NO e. Swelling in your legs or feet (not caused by walking)
 YES NO b. Stroke YES NO f. Heart arrhythmia
 YES NO c. Angina YES NO g. High blood pressure
 YES NO d. Heart failure YES 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?

YES NO a. Frequent pain or tightness in your chest YES NO k. Heartburn or indigestion that is not related to eating
 YES NO b. Pain or tightness in your chest during physical activity YES NO l. Any other symptoms that you think might be related to heart
 YES NO c. Pain or tightness in your chest that interferes with your job
 YES 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?

YES NO a. Breathing or lung problems YES NO c. Blood pressure
 YES NO b. Heart trouble YES NO d. Seizures (fits)

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

YES NO a. Eye irritation YES NO e. General weakness or fatigue
 YES NO b. Skin allergies or rashes YES NO f. Any other problem that interfere with the use of a respirator
 YES NO c. Anxiety

Date: 5/3/26 Candidate/Employee Signature: UK

DR. SARDIA ALIREZA NIKSERESH
 General Practitioner
 Medical License No. 55295
 This is a legally binding document. All Mail



HEARING CONSERVATION QUESTIONNAIRE

00

CANDIDATE / EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name	Position	
64582768		NARSIMLU WOODANNA		
Nationality	Age	Sex	Company	Location
INDIAN	60Y	M		

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: **NIL**

<input type="checkbox"/> Hunting	<input type="checkbox"/> Car races	<input type="checkbox"/> Blast shooting	<input type="checkbox"/> Woodwork	<input type="checkbox"/> Target shooting
<input type="checkbox"/> Power tools	<input type="checkbox"/> Mower	<input type="checkbox"/> Concrete / Sand	<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: **NIL**

<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:

<input type="checkbox"/> Meningitis	<input checked="" 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 checked="" 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/lympenic membrane	

5 - Check ALL that you are currently suffering from:

<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Cold/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 orinnitus? 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: 5/3/26  Candidate/Employee Signature: U.A.

PHYSICAL ASSESSMENT FORM

01

CANDIDATE / EMPLOYEE IDENTIFICATION				
Civil ID / Passport #	Company ID #	Name	Position	
64582768		NARSIMLU WOODARANA		
Nationality	Age	Sex	Company	Location
INDIAN	60Y	M		

VITAL SIGNS				
Height	161 cm	Weight	79 Kg	BMI
				30.9
Pulse	84 /min	Medical Practitioner Name	Signature	
			DR. SADRA ALIREZA NIKSERESHI	

Blood Pressure: 140/85
 DR. SADRA ALIREZA NIKSERESHI
 General Practitioner
 MOH Lic. No: 25405
 MMC Specialty Hospital, Al Hall

VISUAL SYSTEM				
Visual Acuity Test	Right Uncorrected 6/6	Left Uncorrected 6/6	Right Corrected	Left Corrected
Colour Vision Test	# of Plates passed	Inform the Plates A failed	Visual Field Test	Stereoscopic Vision Test
			Normal	Normal
			Abnormal	Abnormal
Date of Examination	Medical Practitioner Name			Signature

DR. SADRA ALIREZA NIKSERESHI
 General Practitioner
 MOH Lic. No: 25405
 MMC Specialty Hospital, Al Hall

RESPIRATORY SYSTEM				
[1] Spirometry Test	Smoking Status: <input type="checkbox"/> Never <input type="checkbox"/> Ever Used <input type="checkbox"/> Current			
	Patient's Posture During Test: <input type="checkbox"/> Standing <input type="checkbox"/> Sitting			
Diagnosis	<input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Other			
Acceptability Criteria (used at each replicate)	Repeatability Criteria (used at each replicate)			
<input type="checkbox"/> Free from artifacts	<input type="checkbox"/> Satisfactory expiration			
<input type="checkbox"/> Good start	<input type="checkbox"/> NOT satisfactory			
	<input type="checkbox"/> +3 acceptable cycles FEV1 values AND FVC values within 0.15L (150 ml)			
	<input type="checkbox"/> Total of THREE to EIGHT tests performed			
	<input type="checkbox"/> The patient CAN NOT or SHOULD NOT cooperate			
The Patient Demonstrated:	<input type="checkbox"/> Good Effort <input type="checkbox"/> Difficulty following instructions <input type="checkbox"/> Ability to sustain only one good effort <input type="checkbox"/> Poor Effort <input type="checkbox"/> Cooperation			
Date of Examination	Medical Practitioner Name			Signature

[2] Chest Shape and Movement	<input checked="" type="checkbox"/> Normal	If abnormal, describe below	[3] Chest Percussion	<input checked="" type="checkbox"/> Normal	If abnormal, describe below
	<input type="checkbox"/> Abnormal			<input type="checkbox"/> Abnormal	
	<input type="checkbox"/> Not Examined			<input type="checkbox"/> Not Examined	
[3] Air Entry in Both Lungs	<input checked="" type="checkbox"/> Normal	If abnormal, describe below	[4] Breath sounds	<input checked="" type="checkbox"/> Normal	If abnormal, describe below
	<input type="checkbox"/> Abnormal			<input type="checkbox"/> Abnormal	
	<input type="checkbox"/> Not Examined			<input type="checkbox"/> Not Examined	
Date of Examination	Physician Name			Signature	

ENT SYSTEM				
[1] Otoscopy	Right	Left	Eardrum Position	[2] Hearing Test
Ear Canal	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Normal	Whisper Test
Collyre	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Retracted	<input type="checkbox"/> Abnormal
	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Bulging	<input type="checkbox"/> Not Exam
Drainage	Right	Left	Left	None
	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Retracted	<input type="checkbox"/> Not Exam
	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Unknown	<input type="checkbox"/> Bulging	
Perforation	Right	Left	Right	None
	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Considerable	
	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Mild	
Cornea	Right	Left	Left	None
	<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> A lot	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
	<input type="checkbox"/> Some	<input type="checkbox"/> Impacted	<input type="checkbox"/> Considerable	
	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Not Exam	<input type="checkbox"/> Mild	
	Left			Audiometry Done
	<input checked="" type="checkbox"/> None			<input type="checkbox"/> Yes
	<input type="checkbox"/> Some			<input type="checkbox"/> No
	<input type="checkbox"/> Impacted			
	<input type="checkbox"/> Not Exam			
			Audiologist Name:	Hearing
			Signature:	Cardiophone refilled
				<input type="checkbox"/> Yes
				<input type="checkbox"/> No

DR. SADRA ALIREZA NIKSERESHI
 General Practitioner
 MOH Lic. No: 25405
 MMC Specialty Hospital, Al Hall

ENT SYSTEM

(1) Nose Assessment		(2) Throat Assessment	
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Normal	If abnormal, describe below:
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined	

CARDIOVASCULAR SYSTEM

(1) Heart Sounds		(2) Heart Murmurs	
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Present	If present, describe below:
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Absent	
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined	
(3) Peripheral Pulses		(4) Peripheral Veins	
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Normal	If abnormal, describe below:
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined	

NEUROLOGICAL SYSTEM

(1) Mental Status		(2) Cranial Nerves	
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Normal	If abnormal, describe below:
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined	
(3) Motor System		(4) Reflexes	
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Normal	If abnormal, describe below:
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined	
(5) Sensory System		(6) Coordination, Station, Gait	
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Normal	If abnormal, describe below:
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined	

MUSCULOSKELETAL SYSTEM

(1) Hand and Wrist		(2) Elbow and Shoulder	
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Normal	If abnormal, describe below:
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined	
(3) Hip		(4) Knees	
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Normal	If abnormal, describe below:
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined	
(5) Foot and Ankle		(6) Spine and Back	
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Normal	If abnormal, describe below:
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined	

OTHER

(1) Skin, Extremities		(2) Head & Neck	
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Normal	If abnormal, describe below:
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined	
(3) Mouth and Teeth		(4) Nasal Orifices	
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Normal	If abnormal, describe below:
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined	
(5) Abdominal Organs		(6) Lymph Nodes	
<input checked="" type="checkbox"/> Normal	If abnormal, describe below:	<input checked="" type="checkbox"/> Normal	If abnormal, describe below:
<input type="checkbox"/> Abnormal		<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Not Examined		<input type="checkbox"/> Not Examined	

Date of Examination: 5/3/26

Physician Name: _____

DR. SADRA ALIREZA NIKSERESHT
General Practitioner
M.D. - 1987
1980 Specialty Hospital, AP Hall



Signature:

DEPARTMENT OF LABORATORY MEDICINE

File No: 14329129	Report No: 0183957
Name: NARSIMLU WOOSANNA 6554	Sample Date: 05/03/2026 Time: 8:30
Address:	Received By:
Gender: M Age: 60 Y Nationality: INDIAN	Received Date: Time:
GSM No.: 92509394 ID Card No.: 64582768	Report Date: 05/03/2026 Time: 11:44
Ref. By: DR SADRA NIKSERESHT	Bill No: 0428426 Bill Date: 05/03/2026

INVESTIGATION	RESULT	REFERENCE RANGE
OO FTW PACKAGE-4 For Drivers and Operators (50 years and Above)		
LUMBAR SPINE AP & LAT	Lumbar lordosis is normal. Vertebral bodies & disc spaces are normal. No spodylolysis or listhesis. Posterior elements appear normal. Impression : Normal lumbo sacral spine radiographs	
COMPLETE BLOOD COUNT		
TOTAL WBC COUNT	6.86 x 10 ³ / μL	4.00-11.00 x 10 ³ / μL
DIFFERENTIAL COUNT		
NEUTROPHIL (%)	58.42 %	40-75%
LYMPHOCYTE (%)	27.62 %	20-45%
MONOCYTE (%)	10.78 %	2-8%
EOSINOPHIL (%)	1.79 %	1-6%
BASOPHIL (%)	1.39 %	0-1%
HAEMOGLOBIN	15.47 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	4.82 million/cu	Male :4.5-6.5 million/cu Female:3.9-5.5 million/cu
PLATELET COUNT	192.80 x 10 ³ / μL	150 - 400 x 10 ³ / μL
HEMATOCRIT	45.70 %	Male :42 - 52% Female:37- 47%
MCV	94.90 fl	76 - 96 fl
MCH	32.12 pg	27 - 33 pg
MCHC	33.85 gm/dl	32 - 36 gm/dl

Verified By:

Approved By:



10589

Lab Technologist

Specialist Pathologist

MOH License No: 17976

Electronically signed at: 3/5/2026 11:46:00

Printed at: 05/03/2026 11:46:25 AM

Page : 1 of 5



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nmc specialty hospital

Specialist Pathologist
C.R. No. AGA/17
Specialist Pathologist
[REGISTRATION]
www.nmc.gov.sa
nmc specialty hospital

DEPARTMENT OF LABORATORY MEDICINE

File No: 14329129	Report No: 0183957
Name: NARSIMLU WOOSANNA 6554	Sample Date: 05/03/2026 Time: 8:30
Address:	Received By:
Gender: M Age: 60 Y Nationality: INDIAN	Received Date: Time:
GSM No.: 92509394 ID Card No.: 64582768	Report Date: 05/03/2026 Time: 11:44
Ref. By: DR SADRA NIKSERESHT	Bill No: 0428426 Bill Date: 05/03/2026

INVESTIGATION	RESULT	REFERENCE RANGE
LIPID PROFILE		
TOTAL CHOLESTEROL	3.02 mmol/L	< 5.18 mmol/L
HDL	1.20 mmol/L	>1.5 mmol/L
TRIGLYCERIDES	1.47 mmol/L	Desirable : <2.083 mmol/L Boderline high : 2.83 - 5.67 mmol/L Hypertriglyceridemia >5.65 mmol/L
LDL	1.48 mmol/L	< 2.6 mmol/L
VLDL	0.67 mmol/L	0.128-0.645mmol/L
LIVER FUNCTION TEST		
TOTAL BILIRUBIN	20.50 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	7.30 µ mol/L	Adults :- 0 - 5.0 µ mol/L, Neonates:- 0-10 µ mol/L,
TOTAL PROTIEIN	73.70 g/L	Adults : 66 - 87 g/L
ALBUMIN	43.20 g/L	39.7 - 49.4 g/L
Globulin	30.5 g/L	23-35g/L
SGOT (AST)	53.70 U/L	MALE : up to 40 U/L, FEMALE : up to 32 U/L.
SGPT (ALT)	93.80 U/L	MALE : up to 41 U/L, FEMALE : up to 33 U/L.
ALKPO4 (ALP)	71.00 U/L	Adults: MALES: 40 - 129 U/L, FEMALES: 35 - 104 U/L.
Gamma GT (GGT)	54.00 U/L	MALE- 8 - 61 U/L, FEMALE- 5 - 36 U/L
RENAL FUNCTION TEST		
URIC ACID	191.00 µ mol/L	MALE: 202.3 - 416.5 µ mol/L, FEMALE: 142.8 - 339.2 µ mol/L

Verified By:

Approved By:



10589

Lab Technologist

Specialist Pathologist

MOH License No: 17976

Electronically signed at: 3/5/2026 11:45:00

Printed at: 05/03/2026 11:46:25 AM

Page : 3 of 5





DEPARTMENT OF LABORATORY MEDICINE

File No: 14329129	Report No: 0183957
Name: NARSIMLU WOOSANNA 6554	Sample Date: 05/03/2026 Time: 8:30
	Received By:
Address:	Received Date: Time:
Gender: M Age: 60 Y Nationality: INDIAN	Report Date: 05/03/2026 Time: 11:44
GSM No.: 92509394 ID Card No.: 64582768	Bill No: 0428426 Bill Date: 05/03/2026
Ref. By: DR SADRA NIKSERESHT	

INVESTIGATION	RESULT	REFERENCE RANGE
CREATININE	62.00 µmol/L	Adults: MALE: 62 – 106 µmol/L FEMALE: 44 - 80 µmol/L
UREA	3.80 mmol/L	2.76 - 8.07 mmol/L
ECG		
SPIROMETRY		
SICKLE CELL	NEGATIVE	
Method : Solubility test (If Positive , Hb Electrophoresis / HPLC to be done to confirm Sickie cell anaemia / Trait).		
AUDIOMETRY		
CHEST X RAY PA		
TREAD MILL TEST		
DRUGS SCREENING ONLY IN URINE		
OPIATE (OPI)	NEGATIVE	
MORPHINE (MOP)	NEGATIVE	
COCCAINE (COC)	NEGATIVE	
AMPHETAMINE (AMP)	NEGATIVE	
MARIJUANA (THC)	NEGATIVE	
BENZODIAZEPINES (BZO)	NEGATIVE	
PHENCYCLIDINE (PCP)	NEGATIVE	
TCA -TRICYCLIC ANTIDEPRESSANTS (TCA)	NEGATIVE	
BARBITURATES (BAR)	NEGATIVE	
METHAMPHETAMINE (MET)	NEGATIVE	
METHADONE (MTD)	NEGATIVE	
METHYLENEDIOXYMETHAMPHETAMINE (MDMA)	NEGATIVE	
DRUGS SCREENING ONLY IN URINE		
OPIATE (OPI)	NEGATIVE	

Verified By:

Approved By:

10589

Lab Technologist

Specialist Pathologist

MOH License No: 17976

Electronically signed at: 3/5/2026 11:46:30

Printed at: 05/03/2026 11:46:25 AM

Page : 4 of 5



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DEPARTMENT OF LABORATORY MEDICINE

File No: 14329129	Report No: 0183957
Name: NARSIMLU WOOSANNA 6554	Sample Date: 05/03/2026 Time: 8:30
Address:	Received By:
Gender: M Age: 60 Y Nationality: INDIAN	Received Date: Time:
GSM No.: 92509394 ID Card No.: 64582768	Report Date: 05/03/2026 Time: 11:44
Ref. By: DR SADRA NIKSERESHT	Bill No: 0428426 Bill Date: 05/03/2026

INVESTIGATION	RESULT	REFERENCE RANGE
MORPHINE (MOP)	NEGATIVE	
COCAINE (COC)	NEGATIVE	
AMPHETAMINE (AMP)	NEGATIVE	
MARIJUANA (THC)	NEGATIVE	
BENZODIAZEPINES (BZO)	NEGATIVE	
PHENCYCLIDINE (PCP)	NEGATIVE	
TCA -TRICYCLIC ANTIDEPRESSANTS (TCA)	NEGATIVE	
BARBITURATES (BAR)	NEGATIVE	
METHAMPHETAMINE (MET)	NEGATIVE	
METHADONE (MTD)	NEGATIVE	
METHYLENEDIOXYMETHAMPHETAMINE (MDMA)	NEGATIVE	

Verified By:



10589

Lab Technologist

MOH License No: 17076
Electronically signed at: 3/5/2026 11:45:00

Approved By:

Specialist Pathologist

Printed at: 05/03/2026 11:46:25 AM

Page: 5 of 5



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DEPARTMENT OF LABORATORY MEDICINE

File No: 14329129	Report No: 0183981
Name: NARSIMLU WOOSANNA 6554	Sample Date: 05/03/2026 Time: 11:59
Address:	Received By:
Gender: M Age: 60 Y Nationality: INDIAN	Received Date: Time:
GSM No.: 92509394 ID Card No.: 64582768	Report Date: 05/03/2026 Time: 13:22
Ref. By: DR SADRA NIKSERESHT	Bill No: 0428476 Bill Date: 05/03/2026

INVESTIGATION	RESULT	REFERENCE RANGE
HbA1C	8.6%	NORMAL : < 6.0 GOOD DIABETES CONTROL : <7 FAIR DIABETES CONTROL : 7-8 POOR DIABETES CONTROL : >8

Verified By:

10589

Lab Technologist

MOH License No: 17976
Electronically signed at: 3/5/2026 1:22:00

Approved By:

Specialist Pathologist

مركز التخصصي في الرعاية الصحية
nmc specialty hospital

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Printed at: 05/03/2026 1:56:08 PM

Page: 1 of 1

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AUDIOMETRY REPORT

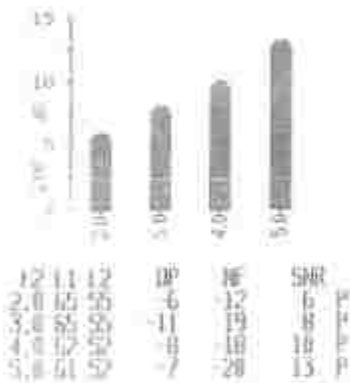
NarSimlu Waddan

0107-05
17-30-12 00:45
DP 46 4 SNR 400
SN: G11005649 G12014594

Sex m MRN 14329129 Date of Test 05/3/26

NOTE:

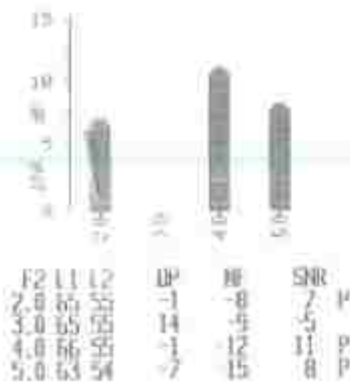
Left: Pass



0107-05
17-30-12 00:46
DP 46 4 SNR 400
SN: G11005649 G12014595

NOTE:

Right: Pass



Signature of the Technician

Vitalograph

Pulmonary Function Report

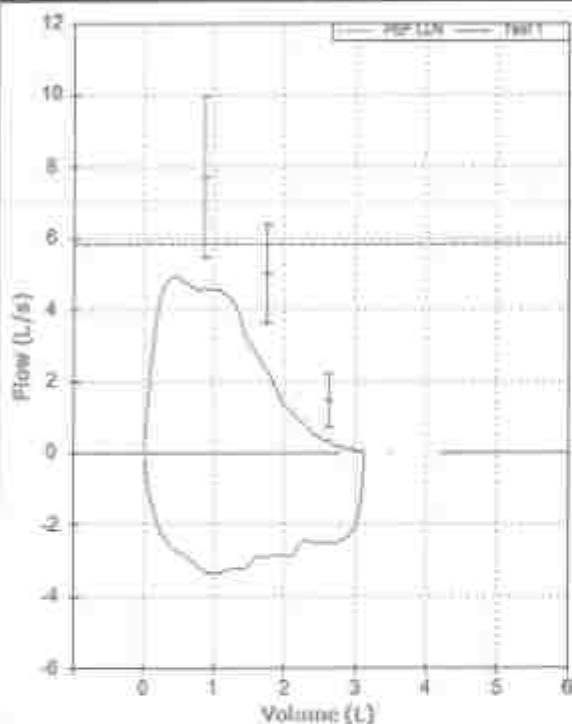
Subject Information

ID:	2026064_092248654	Alternate ID:	14329129	Middle Name:	
Last Name:	Woosanna	First Name:	Nersimly	Date of Birth:	8/20/1965
Population:	MIDDLE EAST	Gender:	Male	Weight:	79.0 kg
Age:	60	Height:	161 cm		
BMI:	30.5	Smoking:	Non Smoker		

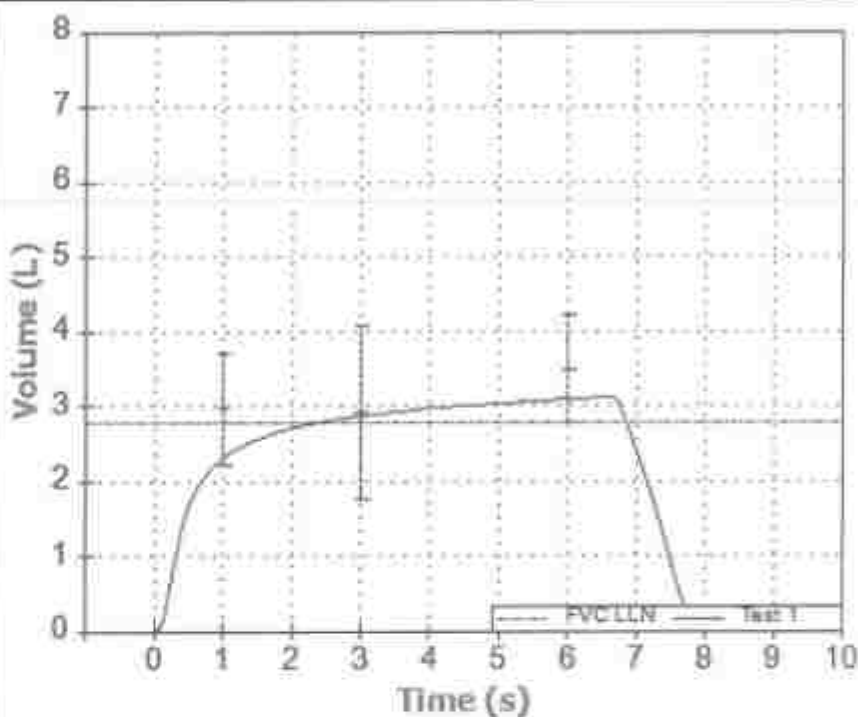
Test Session Information

Test Date:	3/5/2026 09:25	Device:	ALPHA Touch	Serial Number:	32166
No. of Tests:	3	Accuracy Chk:	5/30/2019 15:42	User:	Administrator
Pred. Values:	Golshan	Pred. Factor:	100%	Posture:	Sitting

Flow/Volume Graph



Volume/Time Graph



Results

Parameter	Pred	LLN	ATS/ERS Best	% Pred.	Z-Score
FVC (L)	3.49	2.77	3.12	89	-0.84
FEV1 (L)	2.97	2.22	2.38	80	-1.29
FEV1 Ratio	0.76	0.65	0.76	100	0.00
FEV6 (L)	3.49	2.77	3.09	89	-0.91
PEF (L/min)	511	350	298*	58	-2.17
FEF25-75 (L/s)	3.85	2.84	2.03*	53	-2.96

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

Session Quality and Repeatability Information

Session Grade	FVC Rep:	FEV1 Rep:	Slow Start of test	End of test criteria not achieved	Cough detected in 1st second
D	-	-	0 blow(s)	0 blow(s)	0 blow(s)

Computer Suggest Interpretation

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

Reference Protocol

FVC					
FEV1					
FEV1 Ratio					

LLN

Reference

ULN

NARASIMLIJ, WOOSANNA

14129129

Probe

Exam Start 3/1/2026 10:17:00 AM

Print Time 3/5/2026 10:17:06 AM

Date of Birth Gender Male

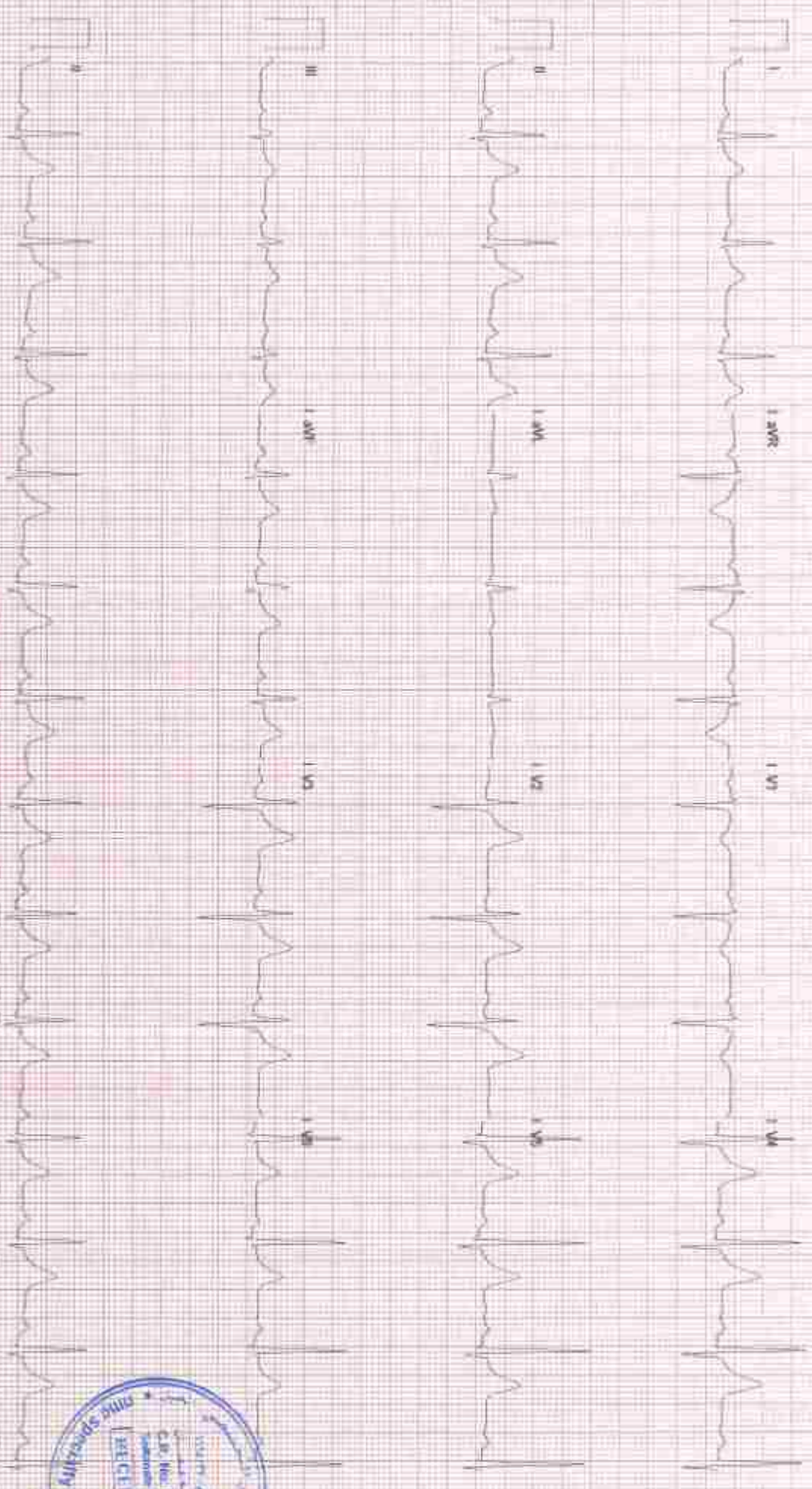
00:05 Pre Exc

--- MPH

---%

RATE ---

BP ---/---



Scale: 0.5 sec/div

Speed: Standard 0.05 sec/div 30 Hz SQE

Beidock, C. Rajaratnam, QUINCY

RECORD

3.1.26

WOOSANNA, NARASIMLU
14329129

Patient Information

3/5/2026 10:17:00 AM

Bruce

ID: 14329129

Second ID:

Admission ID:

Date of Birth:

Height: 161 cm

Gender: Male

Age: 60 Years

Weight: 79 kg

Race: Unknown

Indications:
test

Medications:
ANTI DIABETICS, Antihypertensive

Referring Physician: DR.ERFAN

Location: NM, C HOSPITAL AL HAL

Procedure Type: TMT

Attending Phy: DR.ERFAN

Target HR: 135 bpm (85%)

Reasons for end: ACHIEVED METS, Target HR

Technician: ARUN

Max HR(%MPHR): 155 bpm (95%)

Symptoms: NO CHEST PAIN

Diagnosis

Notes

Conclusions:

The patient was tested using the Bruce protocol for a duration of 07:55 min:ss and achieved 10.3 METs. A maximum heart rate of 155 bpm with a target predicted HR of 135 bpm was obtained at 07:50. A maximum systolic blood pressure of 187/89 was obtained at 05:29 and a maximum diastolic blood pressure of 106/65 was obtained at 02:28. A maximum ST depression of -1.9 mm in AVR occurred at 06:50. A maximum ST elevation of +3.4 mm in V3 occurred at 09:00. The patient reached target heart rate with appropriate heart rate and blood pressure response to exercise. No significant ST changes during exercise or recovery. Ischemia. Normal exercise stress test.

Reviewed by:

Signed by:

UNCONFIRMED REPORT

Date:



WOOSANNA, NARASIMLU
14329129

Exam Summary

3/5/2026 10:17:00 AM

Bruce

Summary
 Exercise Time: 07:55
 Leads with 100uV ST I, II, III, aVR, aVF, V2, V3, V4, V5
 P/CS: 0
 Duke Treadmill Score: -3

Max Values
 Speed: 3.4 MPH
 Grade: 14 %
 METs: 10.3
 HR*BP: 254/32 BPM * mmHg
 ST/HR Index: 1.25 uV/bpm in V1 at 00-10

Max ST
 ST elevation: 3.4 mm in V3 at 09:00
 ST depression: -1.9 mm in aVR at 08:50

Max ST Changes
 ST elevation change: 1.9 mm in V3 at 09:00
 ST depression change: -1.3 mm in II at 07:20

STAGE SUMMARY

ST measurement based on J-ECG

	Speed (MPH)	Grade (%)	HR (BPM)	BP (mmHg)	METs	HR*BP	I	II	III	aVR	aVL	aVF	V1	V2	V3	V4	V5	V6
BP	0.0	0.0	75	154/95	-	11550	0.6	1.1	0.5	-1	0	0.8	-0.2	1.7	1.5	1.4	1.2	0.8
START EXE	0.0	0.0	79	-	1.3	-	0.7	1.1	0.3	-1	0.2	0.7	-0.2	1.0	1.5	1.4	1.2	0.7
EXE 02:28	1.7	10.0	113	168/95	4.7	18758	0.3	0.9	0.5	-0.7	-0.1	0.7	0	1.3	1.7	1.4	1	0.4
ETRACE 1	1.7	10.0	115	-	4.7	-	0.3	0.9	0.6	-0.7	-0.2	0.7	0.1	1.2	1.9	1.4	0.9	0.4
BP	2.5	12.0	136	187/89	7.1	25432	0.1	0.2	0	-0.3	0	0.1	0.1	1.3	1.5	1.1	0.6	-0.1
ETRACE 2	2.5	12.0	138	-	7.1	-	0.2	0.3	0.1	-0.4	0	0.2	0.2	1.3	1.5	1.2	0.9	-0.2
Peak	3.4	14.0	158	-	10.3	-	0.5	0.3	-0.2	-0.5	0.3	0	0.2	1.4	1.8	1.2	0.8	0.1
Treadmill Stopped	0.0	0.0	156	-	10.0	-	0.3	0.5	0.1	-0.5	0.3	0	0.2	1.2	1.9	1.4	0.7	0.3
BP	0.0	0.0	106	172/73	5.5	18202	0.4	1	0.5	-0.8	-0.1	0.8	0	1.0	2.1	1.5	0.8	0.3
REC 02:39	0.0	0.0	103	156/83	4.0	16068	0.3	0.7	0.3	-0.6	0.1	0.5	0	1.6	1.7	1.1	0.7	0.2
BP	0.0	0.0	100	155/67	2.2	15500	0.4	0.7	0.2	-0.6	0	0.4	0	1.5	1.5	1	0.7	0.3
REC 04:27	0.0	0.0	99	152/67	1.0	15080	0.5	0.9	0.3	-0.6	0.1	0.6	-0.1	1.6	1.4	1.1	0.8	0.4
BP	0.0	0.0	100	-	1.0	-	0.5	0.9	0.3	-0.6	0.1	0.6	-0.1	1.6	1.4	1.1	0.8	0.4
REC 05:43	0.0	0.0	100	-	1.0	-	0.5	0.9	0.3	-0.6	0.1	0.6	-0.1	1.6	1.4	1.1	0.8	0.4

ST LEVEL (mm)



nmc specialty hospital, al-hail

P.O BOX : 613, Postal Code : 133 al-hail Sultanate of Oman

SI No: 55389	Bill Date: 05/03/2026	Report Date :05/03/2026 09:27:27
Patient Name: NARSIMLU WOOSANNA 6554	Reg No: 14329129	
Age: 60Y	Gender: Male	Nationality: INDIA
Address:		
Company: TRUCKOMAN SOUTH LLC	Policy No:	
Certificate No:		
Region: LUMBAR SPINE AP & LAT		
Referred Doctor:	Consultant Name: DR SADRA NIKSERESHT	

LUMBAR SPINE AP & LAT VIEWS

Anterior osteophytes noted at L4 level
 Generalized osteopenia noted.
 Rest of the vertebral bodies & disc spaces appears normal.
 Posterior elements appear normal.
 Para vertebral soft tissue appears normal.
 No obvious fracture seen.

IMPRESSION :

- Age related degenerative changes.

Suggested clinical correlation .



[Handwritten Signature]

DR. ANAMIKA CHATURVEDI
 Specialist - Radiology
 MOH Lic. No: 7709
 nmc specialty hospital, Al Hail

DR ANAMIKA CHATURVEDI



nmc specialty hospital, al-hail

P.O BOX : 613, Postal Code : 133 al-hail Sultanate of Oman

SI No: 55389	Bill Date: 05/03/2026	Report Date :05/03/2026 09:28:08
Patient Name: NARSIMLU WOOSANNA 6554	Reg No: 14329129	
Age: 60Y	Gender: Male	Nationality: INDIA
Address:		
Company: TRUCKOMAN SOUTH LLC	Policy No:	
Certificate No:		
Region: CHEST X RAY PA		
Referred Doctor:	Consultant Name: DR SADRA NIKSERESHT	

CHEST X RAY PA

Both lung fields are clear.

Bilateral CP angles are clear

Cardiac silhouette appears normal .

Both domes of diaphragm are normal.

Bony thorax appears normal

Impression:

- *No significant abnormality.*

Suggested clinical correlation



05/03/2026 09:27:51

Elegant Medical Center LLC

DR ANAMIKA CHATURVEDI

Radiology

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T: (+968) 2426 9222, F: (+968) 2426 9286, E: nmc.hail@nmcoman.com

MOH License No: 7709

Disclaimer : This is an electronically generated report and does not require a doctor's signature

OQ FTW for Narsimlu #6554 - 05.03.20

From Sudheesh Krishnan <sudheesh.krishnan@truckomangroup.com>

Date: Thu 3/5/2026 7:21 AM

To: Customercare Hail [NMC Oman] <customercare.hail@nmcoman.com>; Insurance Hail [NMC Oman] <insurance.hail@nmcoman.com>

Cc: Sampuran Sannthu <sampuran@truckomangroup.com>; Sahaya Jayaraj <Sahaya@truckomangroup.com>; Davis George <davis@truckomangroup.com>; Muatasim Al Mandhari <Muatasim@truckomangroup.com>; Jeyasingh <jeyasingh@truckomangroup.com>

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Do NOT ACT on any instructions given on email unless you recognize the Sender. If in doubt please contact the Sender directly for confirmation. Do not click on links or open attachments unless you recognize the sender.

Good morning Shellen,

Can you arrange the OQ FTW for Narsimlu #6554 today? and please share the report once completed. Thank you.

Regards,

Sudheesh Krishnan
TER HSEA
GSM: +968 94885082



REPORT

View & Reference • Calculators

Calculator

About

References

Default Units

Copy Results

Framingham Risk Score (2008)

Questions

- | | |
|--|------------------|
| 1. Gender? | Male |
| 2. Age? | 60 dx |
| 3. Total Cholesterol? | <4.14 mmol/L |
| 4. HDL? | 1.17-1.29 mmol/L |
| 5. Systolic Blood Pressure? | 140-149 mmHg |
| 6. On Medication for Hypertension? | Yes |
| 7. Smoker? | No |
| 8. Diabetic? | Yes |
| 9. Known Vascular Disease (CAD, PVD, S...) | No |

About

The FRs estimate the 10-year risk of (manifesting clinical CVD (CAD, Stroke, PVD, Cef, cardiac death). Although not included in the 2008 model, it is common practice to double the FRs if there is a FHx of premature CAD (i.e. first degree relative (men <55), women <65)).

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 ≥10% are considered high risk. The lipid guidelines recognize risk equivalents as a distinct category that warrant immediate treatment. For patients with an ESC SCORE ≥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 ≥5% then intensive therapy to reach high-risk targets is recommended.

References

Rakhi B. Silcoff, Agostino, Sr., Ramakrishnan S. Vasan, Michael J. Pencina, Hilary A. Wolf, Mark Costello, Joseph M. Massaro and William B. Kannel. *General cardiovascular risk profile for use in primary care: the Framingham Heart Study.* *Circulation* 2008 February 23; 117 (8): 148-53

McPherson R et al. *Canadian Cardiovascular Society Lipid Guidelines: recommendations for the diagnosis and treatment of dyslipidemia and prevention of cardiovascular disease.* *Canadian Journal of Cardiology* 2006; 22 (11): 913-27

Management of Blood Cholesterol in Adults. *Scientific Evidence* Review from the Department of Health, UK.

van Gennip et al. *European guidelines on cardiovascular disease prevention in clinical practice: executive summary. Fourth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice (Consensus Document) of the societies and by invited experts.* *European Heart Journal*, Volume 28, Issue 19, October 2007, Pages 2375-2414

The Framingham Risk Score (2008) calculator is created by QMED.

Results

10-year risk of CVD (2008) FRs

<10%

10-year risk of CVD

High Risk*

10-year risk of vascular age

>40 Years*

*Due to this patient being diabetic, they are placed in the High Risk Category and should be treated based on the following guidelines.

Treatment Guidelines

ATP-III (2004)
Treatment Targets
LDL <100 mg/dL (<2.59 mmol/L)
Non-HDL <130 mg/dL (<3.37 mmol/L)

CCS (2006)
Treatment Targets
LDL <2 mmol/L (<77 mg/dL) or ≥50% decrease in LDL-C
apoB <0.8 g/L (80 mg/dL)

ESC (2007, see link for more)
Treatment Targets
LDL <2.5 mmol/L (<80 mg/dL)
TC/HDL <4.4:1 (mmol/L) (<100:173 mg/dL)

Created by QMED



Lowest Values and Diastolic

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