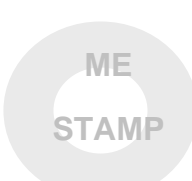


1. Name		2. Client ID	
3. Comments and follow-up on issues raised in the Application for Medical Certificate or history taking:			
History:			
Medication:			

4. CVD Risk Assessment (to be completed as per General Direction following NHF guidelines)																					
<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="background-color: #f2f2f2;">Height (no shoes)</td><td style="text-align: right;">cm</td></tr> <tr><td style="background-color: #f2f2f2;">Weight (unclothed)</td><td style="text-align: right;">kg</td></tr> <tr><td style="background-color: #f2f2f2;">BMI</td><td></td></tr> <tr><td style="background-color: #f2f2f2;">BP</td><td style="text-align: right;">mmHg</td></tr> <tr><td style="background-color: #f2f2f2;">Pulse</td><td style="text-align: right;">per min</td></tr> <tr><td style="background-color: #f2f2f2;">Total Cholesterol</td><td style="text-align: right;">mmol/l</td></tr> <tr><td style="background-color: #f2f2f2;">HDL</td><td style="text-align: right;">mmol/l</td></tr> <tr><td style="background-color: #f2f2f2;">Triglycerides</td><td style="text-align: right;">mmol/l</td></tr> <tr><td style="background-color: #f2f2f2;">Tot Chol/HDL ratio</td><td></td></tr> <tr><td style="background-color: #f2f2f2;">Glucose (if required)</td><td style="text-align: right;">mmol/l</td></tr> </table>	Height (no shoes)	cm	Weight (unclothed)	kg	BMI		BP	mmHg	Pulse	per min	Total Cholesterol	mmol/l	HDL	mmol/l	Triglycerides	mmol/l	Tot Chol/HDL ratio		Glucose (if required)	mmol/l	<p>Please detail risk factor(s) in applicable risk group for:</p> <p>Very high risk (Risk >20%) and Elevated single risk groups (Risk >15%)</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div> <p>OR High Risk Groups (CVD risk as per calculation PLUS additional 5% for any or all of the special factors ticked below):</p> <p>FH premature IHD <input type="checkbox"/></p> <p>Ethnicity <input type="checkbox"/></p> <p>DM with Microalbumin <input type="checkbox"/></p> <p>Type 2 DM >10yr <input type="checkbox"/></p> <p>Type 2 DM with HbA1c >8% <input type="checkbox"/></p> <p>Metabolic Syndrome <input type="checkbox"/></p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: auto; margin-right: auto;"> <p>Calculated 5yr Risk:</p> <p style="font-size: 2em; text-align: center;">%</p> </div> <p style="text-align: center; font-size: 0.8em;">NB: Fresh lipids and glucose tests not required at every examination. Check GD.</p>
Height (no shoes)	cm																				
Weight (unclothed)	kg																				
BMI																					
BP	mmHg																				
Pulse	per min																				
Total Cholesterol	mmol/l																				
HDL	mmol/l																				
Triglycerides	mmol/l																				
Tot Chol/HDL ratio																					
Glucose (if required)	mmol/l																				

5. Eyes	Uncorrected			Corrected			Stand by correction									
Visual acuity	Right	Left	Both	Right	Left	Both	Right	Left	Both							
DISTANCE VISUAL ACUITY (6m) Std: Classes 1,3 = 6/9 Class 2 = 6/12	6/	6/	6/	6/	6/	6/	6/	6/	6/							
INTERMEDIATE VISUAL ACUITY (100cm) Std: N14	N:	N:	N:	N:	N:	N:	N:	N:	N:							
NEAR VISUAL ACUITY (33cm) Std: N5	N:	N:	N:	N:	N:	N:	N:	N:	N:							
TYPE OF CORRECTION USED: Write M for main or S for standby correction (below symbol)	NONE <input type="checkbox"/>	Bifocal 	Trifocal 	Look-over 	Progressive focus 	Contacts <input type="checkbox"/>	Distance Specs <input type="checkbox"/>									
Are the following ALL normal: Lids; Pupils; Lens; Media; Fundi; Visual Fields by confrontation; Eye movements and Cover tests? (If NO, elaborate)							<input type="checkbox"/> Yes	<input type="checkbox"/> No								
(Initial only and as per GD). Standard ISHIHARA 24-plate book Are first 17 plates read with only ONE or fewer errors? Record errors below with an "x"							<input type="checkbox"/> Yes	<input type="checkbox"/> No								
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are the following normal, without unusual features? Please tick:				Yes No		NOTES: Describe below every abnormality in detail. Use and attach continuation sheets if necessary.	
6.1	ENT (inc Eust tube, nasal air entry)	<input type="checkbox"/>	<input type="checkbox"/>				
6.2	Speech satisfactory	<input type="checkbox"/>	<input type="checkbox"/>				
6.3	Conversational Voice Test at 2m	<input type="checkbox"/>	<input type="checkbox"/>				
6.4	Audiogram Normal (if required)	<input type="checkbox"/>	<input type="checkbox"/>				
7	Heart (size, rhythm, sounds)	<input type="checkbox"/>	<input type="checkbox"/>				
8	Vascular system	<input type="checkbox"/>	<input type="checkbox"/>				
9	Lungs & chest	<input type="checkbox"/>	<input type="checkbox"/>				
10	Abdomen and viscera (including hernia)	<input type="checkbox"/>	<input type="checkbox"/>				
11	Lymphatic system – spleen, lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>				
12	Endocrine system	<input type="checkbox"/>	<input type="checkbox"/>				
13	Genito-urinary system	<input type="checkbox"/>	<input type="checkbox"/>				
14	Skin (indicate identifying marks, scars, tattoos)	<input type="checkbox"/>	<input type="checkbox"/>				
15	Locomotor system	<input type="checkbox"/>	<input type="checkbox"/>				
16	Neurological examination (reflexes, equilibrium senses, co-ordination, etc)	<input type="checkbox"/>	<input type="checkbox"/>				
17	Psychiatric examination	<input type="checkbox"/>	<input type="checkbox"/>				
18.1	Urinalysis – No Glucose	<input type="checkbox"/>	<input type="checkbox"/>				
18.2	Urinalysis – No Protein	<input type="checkbox"/>	<input type="checkbox"/>				
19. Routine Spirometry	Predicted	Recorded					
FVC (l)							
FEV1 (l)							
FEV1/FVC (%)							
PEFR (l/min)							
21. Do you know the Applicant? Yes <input type="checkbox"/> No <input type="checkbox"/>				If not, indicate below the type & number of ID used: Driving Licence <input type="checkbox"/> Passport/Airport Security <input type="checkbox"/> Other <input type="checkbox"/> Type Number			
22. Any other relevant reports, findings, concerns or comments:							
	<i>Print Examiner's Name and Address</i>			23. Medical Examiner's Declaration: I hereby certify that I personally identified and examined the applicant named on this medical report and that this report with any attached notes embodies my examination completely and correctly. ME signature _____ Date: _____			