

PT. Inspektindo Sinergi Persada

HEALTH AND MEDICAL CHECK UP

No. 0099/MCU-SHBP/IV/2019

Nama : **Abdillah Muttaqin, Sdr**
Tanggal Lahir : **20 Desember 1989**
Jenis Kelamin : **Pria**
S/N :
Jabatan / Posisi : **Asst. Inspector**

Tanggal MCU : **16 April 2019**

Dilakukan oleh : **dr. Kezia Kartika**
dr. Santoso Suhendro, Sp. Rad
dr. Christiani Muljono, Sp. JP
dr. Diah Adhyaksanti, Sp. P
dr. A. Sony Y, Sp. THT -KL

HEALTH AND MEDICAL CHECK UP

No. 0099/MCU-SHBP/IV/2019

Kepada : **Abdillah Muttaqin, Sdr** Umur/ Tanggal **29 tahun 20 Des 1989** Pria
 Dept : **PT. Inspektindo Sinergi Persada**

Berikut adalah hasil pemeriksaan Medical Check Up yang telah dilaksanakan pada tanggal **16 April 2019**

TEMUAN

1. Gigi : DMF 3/0/0, Calculus, staining. Gigi 12 Prothesa.
2. Laboratorium DL : Peningkatan eosinofil, GDP.
3. EKG : SR, Early Repolarization.

STATUS

CATEGORY	NOTE
1A	Fit, tidak dijumpai problem kesehatan
1B	Fit, dijumpai problem kesehatan yang tidak serius
2	Fit, dengan problem kesehatan yang dapat menjadi serius - Kelompok resiko rendah
3A	Dengan problem kesehatan yang dapat menjadi serius - Kelompok resiko sedang
3B	Dengan problem kesehatan yang dapat menjadi serius - Kelompok resiko tinggi
4	Unfit, dengan keterbatasan fisik untuk melakukan pekerjaan secara normal, hanya cocok untuk pekerjaan ringan
5	Unfit, sedang sakit, perawatan rumah sakit atau dalam kondisi yang tidak memungkinkan untuk melakukan pekerjaan (status ijin sakit)

KESIMPULAN**FIT**sebagai **Asst. Inspector**

di Lokasi Kerja

PT. Inspektindo Sinergi Persada**SARAN**

1. Melakukan perawatan rutin ke Dokter Gigi minimal 6 bulan 1x.
2. Periksa laboratorium gula darah puasa 1 bulan kemudian.

Berlaku : **16 April 2020**

Bila masih ada hal yang perlu diperjelas, mohon segera menghubungi Dokter Pemeriksa. Terimakasih atas kerjasamanya

Dokter Pemeriksa,


dr. Kezia Kartika

Medical Department

HEALTH AND MEDICAL CHECK UP

PHYSICAL EXAMINATION

Name	Abdillah Muttaqin, Sdr	S/N		DEPT	Inspektindo Sinergi Persa
------	------------------------	-----	--	------	---------------------------

I. GENERAL CONDITION

Blood Pressure (mmHg)	120/70	Pulse (x/mt)	80	Respiration (x/mt)	20	Temp (°C)	36,5
Weight (kg)	52	Height (cm)	169	BMI (kg/m ²)	18,21	Waist (cm)	68

* BMI = W / H² (Underweight = < 18-25, Overweight 25-30, Obese >30)

II. PHYSICAL

No	PHYSICAL	A = ABNORMAL N = NORMAL	A	N	Describe abnormalities in detail
					(circle words of importance and explain)
1	GENERAL APPEARANCE	Appearance age/nutritional/development/mental & emotional status/Posture/Gait/Speech		N	-
2	HEAD/SCALP	Size/Shape/Tender over sinuses/Hair/Eruption		N	-
3	EYES	Conjunctiva/Sclera/Cornea/Pupils/Ptosis/Tension/Eyelid/Bruit/Reflex/Range of Movement/		N	-
4	EARS	Ext.canal/Membran perforation/Discharge/tophi/Hearing problem/Mastoids		N	-
5	NOSE/SINUSES	Septum/obstruction/turbinates/discharges		N	-
6	MOUTH/THROAT	Odor/Lips/Tongue/Tonsils/Gums/Pharynx		N	-
7	TEETH	Caries ⊕, filling (F), Missing (M), Radix ⊕	A		DMF 3/0/0, Calculus, staining. Gigi 12 Prothesa
8	NECK	Adenopathi/Thyroid/Carotids/Trachea/Veins/Mass/Spine/Motion/Bruit		N	-
9	BACK/SPINE	Kyphosis/Scoliosis/Lordosis/mobility/CVA/Bone/Tenderness /other deformities		N	-
10	THORAX	Symmetry/movement/countour/tender		N	-
11	BREAST	Size/coasistensi/Nipples/areolar/discharge/palpable mass/tenderness/nodes/scars		N	-
12	HEART	Rate/rhythm/apical/impulse/Trills/quality of sound/intensity/splitting/extra sound/murmurs		N	-
13	CHEST / LUNG	percussion/Quality of breath sound/rales/wheezing/ronchi/bruit		N	-
14	ABDOMEN	Bowel sounds/appearance/liver/spleen/masses/Hernias,murmur/countour/tenderness/bruit/nodes		N	-
15	GROIN	Hernia/inguinal nodes/femoral pulses		N	-
16	MALE GENITAL	Penis/testis/scrotum epididymis/varicocele/scars/Discharge/circumcised/piercing		N	-
17	FEMALE GENITAL	Vulva/vagina/Cervix/Uterus/adnexae/rectocele/Bartholini gland/urethra/discharge			-
18	EXTREMITIES	Deformity/clubbing/cyanoosis/edema/nail/periperal pulses/calf tenderness/joints for swelling/ROM		N	-
19	JOINTS	ROMS/swelling/inflammation/Deformity		N	-
20	SKIN	Color/birthmark/scars/tatoos/texture/rash/eczema/ulcers/piercing		N	-
21	NEUROLOGICAL	Reflexes/cranial nerve/tremor/paralysis/motoric/sensoric(touch,prick,vibrate)/coordination/romberg		N	-
22	MUSCULAR SYSTEM	Strength/wasting/development		N	-
23	RECTAL EXAM	Sphincter tone/hemorrhoids/fissure/masses/prostate		N	-

SUPPORTIVE INVESTIGATIONS

Name

Abdillah Muttaqin, Sdr

I. VISION

Vision	Unaided		With spectacles		Night	Colour Blindness
	Left	Right	Left	Right		
						<input checked="" type="checkbox"/> Normal
Distant	6/6	6/6	-	-		<input type="checkbox"/> Red - Green Absent
Near	20/20	20/20	-	-		<input type="checkbox"/> Colour Blind
Visual fields (normal > 70°)			Left	-		Right
COMMENT :	-					

II. LABORATORIUM SUMMARY

<input type="checkbox"/> Normal	COMMENT :	Laboratorium DL : Peningkatan eosinofil, GDP.
<input checked="" type="checkbox"/> Abnormal		

III. CHEST X-RAY

Pneumoconiosis	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If Yes - ILO Classification	-	
Evidence of TB	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Other Abnormalities	-	
COMMENT :	-	

IV. ECG (Optional for over 35 years of age)

See attached result

<input type="checkbox"/> Normal	COMMENT :	SR, Early Repolarization
<input checked="" type="checkbox"/> Abnormal		

V. TREADMILL (Optional for over 40 years of age)

See attached result

<input checked="" type="checkbox"/> Normal	COMMENT :	Response ischemic negative
<input type="checkbox"/> Abnormal		

VI. SPIROMETRY (Optional for dust exposure, respiratory chronic disease,...)

Test	Predicted	Observed	Percentage	
VC	5	4	73	%
FVC	5	4	81	%
FEV 1	4	4	93	%
FEV/FVC	82	103	126	%
COMMENT :	Dalam batas normal			

VII. AUDIOMETRY (Optional for noise exposure, previous hearing problem)

See attached result

CONCLUSION	Change since last audiometric examination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Normal	If Yes, what change :	-	
<input checked="" type="checkbox"/> Abnormal	Recommended action :	-	
Refer to safety department :		<input type="checkbox"/> Yes	<input type="checkbox"/> No

VIII. USG

COMMENT :	Dalam batas normal
-----------	--------------------

SH

**FORMULIR PEMERIKSAAN MATA
 EYE EXAMINATION FORM**

ABDILLAH MULLAQIM, SM
 DOB: 20-Dec-1989 / Male
 MR NO: SHKP.00-18-SN-58



Mata Kanan (Right Eye)	Parameter	Mata Kiri (Left Eye)
6/6	Visus (Visual acuity)	6/6
-	Koreksi (Correction)	-
20/20	Adisi (Addition)	20/20
	Gerakan Bola Mata (Eye movement)	
	Kesegarian (Allignment)	
	Kelopak Mata (Eyelid)	
	Konjungtiva (Conjunctiva)	
	Kornea (Cornea)	
	Bilik Mata Depan (COA)	
normal	Pupil	normal
	Iris	
	Lensa (Lens)	
	Vitreous	
	Fundus	
11	TIO	12
	Lapang Pandang (Visual field)	
	Persepsi Warna (Color perception)	

Kesimpulan OD5 Emetropia

BPN. 16/4/2019

Nama dokter & tanda tangan
 Doctor's name & signature

SH

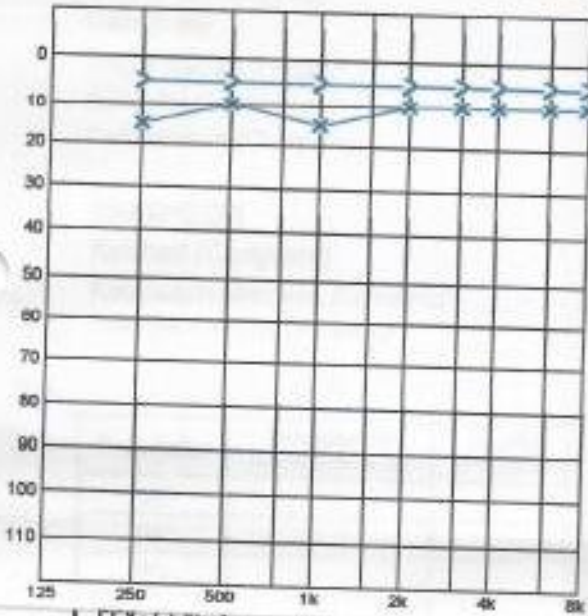
**HASIL PEMERIKSAAN SPIROMETRI
SPIROMETRY REPORT**

ABDILLAH MULLAQIM, SDH
DOB: 20-Dec-1989 / Male
MH No: SHBP.00-18-88-58

No. Rekam Medik (Medical Record)

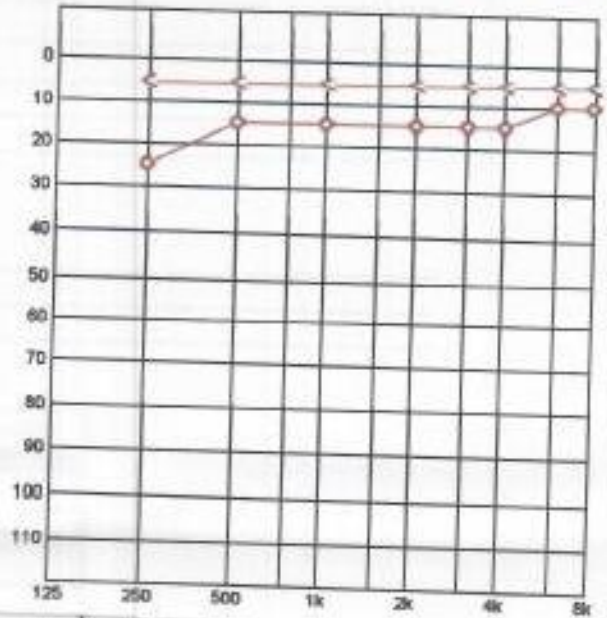
Left Ear

PTA 12 dBHL



Right Ear

PTA 15 dBHL



* Nilai prediksi di hitung berdasarkan nilai prediksi orang Indonesia (PPI)

Kesimpulan (Conclusion)

- Restriksi Ringan / Sedang / Berat
- Obstruksi Ringan / Sedang / Berat
- Restriksi & Obstruksi Ringan / Sedang / Berat

ADI 15 dB
ABJ 11,75 dB } Normal Hearing

Rekomendasi (Recommendation)

: Audiometri berkala

16/4 2019

[Signature]
Nama dokter & tanda tangan

Doctor's name & signature

Patient Name : ABDILLAH MUTTAQIN, SDR
 Address : JALAN GATU NO 441 RT 026
 Age : 29 Thn 3 Bln 27 Hr
 DOB/Sex : 20-12-1989 / Male
 Ward : CHECKUP /
 Physician : Emilia Saminoe, dr
 MR. No. : 00189858

Order Time : 16-04-19 07:35
 Specimen Received : 16-04-19 08:43
 Print Out : 20-04-19 11:54
 Lab No. : 19015731 /
 Patient Category : INSPEKTINDO
 Reg. No. : CPA1904160004
 Page : 1 / 3

Clinical Info :

RUTIN

Test	Result	Unit	Reference Range	Method
HAEMATOLOGY				
Full Blood Count				
Hemoglobin	14.6	g/dL	14.0 - 18.0	
Jumlah Leukosit	5.57	10 ³ /ul	4.50 - 11.50	
Leukogram Jenis				
Eosinofil	H 8	%	1 - 3	
Basofil	1	%	0 - 2	
Neutrofil Segmen	L 48	%	50 - 70	
Limfosit	34	%	18 - 42	
Monosit	9	%	2 - 11	
Hematokrit	42.0	%	40.0 - 54.0	
Jumlah Trombosit	199	10 ³ /ul	150 - 450	
Jumlah Eritrosit	L 4.58	10 ⁶ /uL	4.60 - 6.00	
MCV, MCH, MCHC				
MCV	91.7	fL	80.0 - 94.0	
MCH	31.9	pg	26.0 - 32.0	
MCHC	34.6	g/L	32.0 - 36.0	
Laju Endap Darah 1 jam	6	mm	0 - 13	
CLINICAL CHEMISTRY				
SGPT - SGPT				
SGOT	18.3	U/L	<37	
SGPT	13.7	U/L	<45	
Gamma GT	11.0	U/L	8-61	
Trigliserida	96	mg/dL	Normal: <150 mg/dL Borderline High: 150-199 mg/dL High: 200-499 mg/dL Very high: >= 500 mg/dL	
Kolesterol Total	168	mg/dL	Desirable: <200 mg/dL Borderline High: 200-239 mg/dL High: >= 240 mg/dL	
HDL Kolesterol	44	mg/dL	Major risk: <40 mg/dL Negative risk: >= 60 mg/dL	

Patient Name : ABDILLAH MUTTAQIN, SDR
 Address : JALAN GATU NO 441 RT 028
 Age : 29 Thn 3 Bln 27 Hr
 DOB/Sex : 20-12-1989 / Male
 Ward : CHECKUP
 Physician : Emilia Saminow, dr
 MR. No. : 00188858
 Clinical Info :

Order Time : 16-04-19 07:35
 Specimen Received : 16-04-19 08:43
 Print Out : 20-04-19 11:54
 Lab No. : 19015731
 Patient Category : INSPEKTINDO
 Reg. No. : CPA1904160004
 Page : 2 / 3

RUTIN

Test	Result	Unit	Reference Range	Method
LDL Kolesterol	127	mg/dL	Optimal: <100 mg/dL Near optimal: 100-129 mg/dL Borderline high: 130-159 mg/dL High: 160-189 mg/dL Very high: >190 mg/dL	
Glukosa Darah Puasa	H 105	mg/dL	76 - 100	Hexo
Ureum Darah	11.3	mg/dL	<50	
Kreatinin Darah	0.86	mg/dL	0.70 - 1.20	
*Asam Urat	5.1	mg/dL	3.4 - 7.0	
SEROLOGY				
HBsAg Kualitatif	Non Reaktif		Non Reaktif	
URINALISYS				
Urin Lengkap Makroskopis				
Warna	Kuning		Kuning	
Kejernihan	Jernih		Jernih	
Berat Jenis	L 1.015		1.016 - 1.022	Dipsticks
pH	7.0		4.8 - 7.4	
Leukosit	Negatif	/uL	Negatif	
Nitrit	Negatif	mg/dL	Negatif	
Protein	Negatif	mg/dL	Negatif	
*Glukosa	Normal	mg/dL	Normal	
Keton	Negatif	mg/dL	Negatif	
Urobilinogen	Normal	mg/dL	Normal	
Bilirubin	Negatif	mg/dL	Negatif	
Darah (Blood)	Negatif	/uL	Negatif	
Sedimen				
Leukosit	0-1	/lph	0 - 5	
Eritrosit	0-1	/lph	0 - 1	
Silinder	Negatif			
Sel Epitel	15-17	/lph	0 - 2	

Patient Name : ABDILLAH MUTTAQIN, SDR
 Address : JALAN GATU NO 441 RT 02B
 Age : 29 Thn 3 Bln 27 Hr
 DOB/Sex : 20-12-1989 / Male
 Ward : CHECKUP
 Physician : Emilia Samince, dr
 MR. No. : 00188858

Order Time : 16-04-19 07:35
 Specimen Received : 16-04-19 08:43
 Print Out : 20-04-19 11:54
 Lab No. : 19015731
 Patient Category : INSPEKTINDO
 Reg. No. : CPA1904160004
 Page : 3 / 3

Clinical Info :

RUTIN

Test	Result	Unit	Reference Range	Method
Kristal	Negatif		Negatif	
Bakteri	Negatif		Negatif	
Jamur	Negatif		Negatif	
STOOL				
Faeces Rutin				
Makroskopis				
Warna	Coklat		Coklat	
Konsistensi	Lembek		Lembek	
Lendir	Negatif		Negatif	
Darah	Negatif		Negatif	
Eru	Khas		Khas	
Mikroskopik				
Lekosit	0-2	/lpb	0 - 1	
Eritrosit	0-1	/lpb	0 - 1	
Parasit	Negatif		Tidak ditemukan	
Telur Cacing	Negatif		Tidak ditemukan	

Clinical Pathologist



dr. Yuly Eko P, M.Kes, Sp. PK

Authorized By Desyana

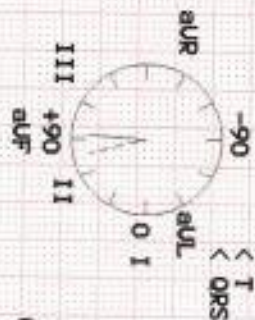
Authorisation Date : 20-04-19 11:54

Penilaian hasil laboratorium hanya dapat diberikan oleh Dokter yang memiliki data klinis pasien.

Siloam Hospitals Balikpapan
 Jalan MT. Haryono Dalam No. 23
 Balikpapan 76114
 Phone. (0542) 8862988

Measurement Results:

QRS : 90 ms
 QT/QTcB : 384 / 384 ms
 PR : (140) ms
 P : (108) ms
 RR/PP : 998 / 995 ms
 P/QRS/T : / 95 / 75 degrees
 QTd/QTcBD : 52 / 52 ms
 Sokolow NK : 8 mV

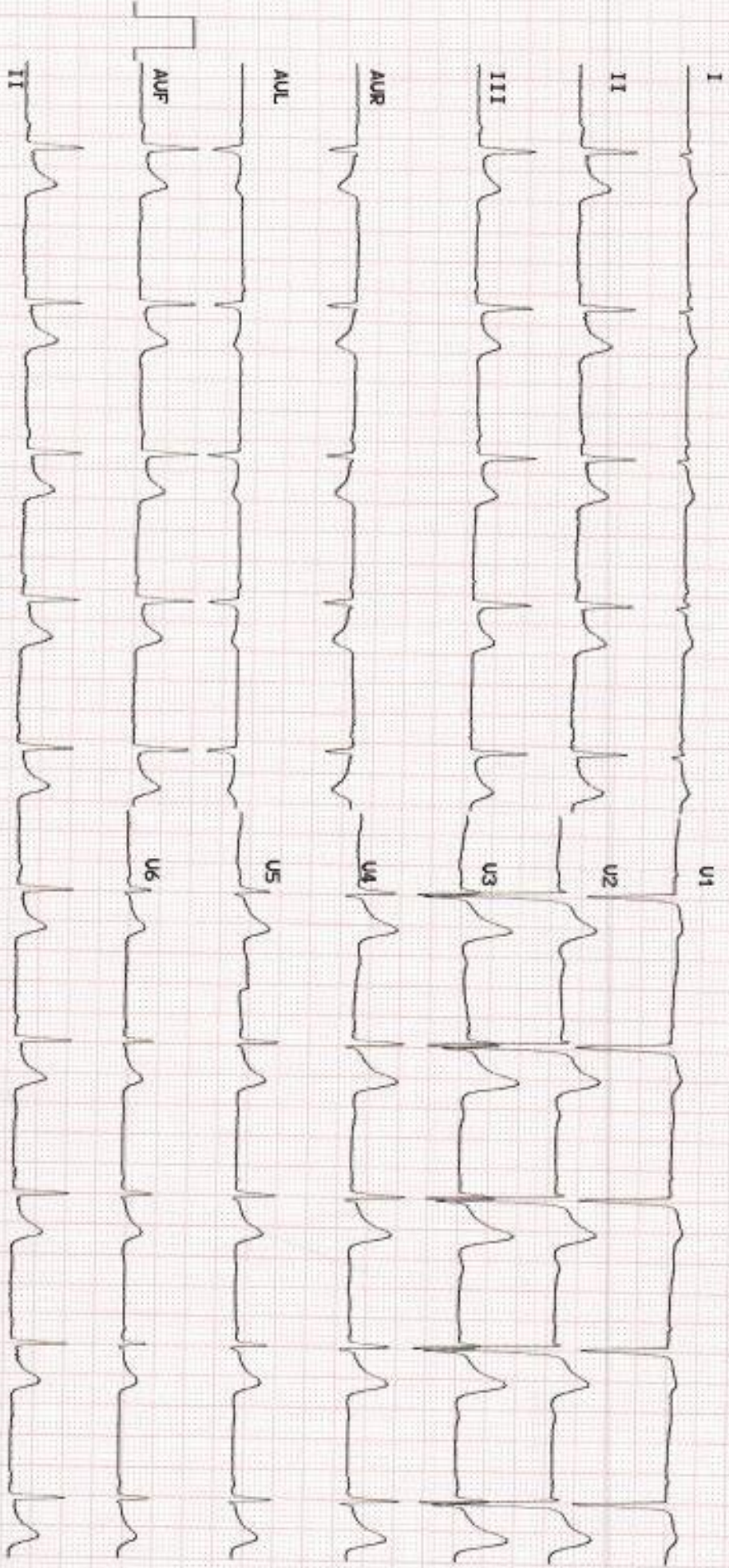


ADJELAM MULIQUIM, SSKP
 DIRIG: 20-Dec-1989 / MAM
 MR NO: SHMP.00-18-88-58

Dr. Farly ~~Frederick~~ Repolarization

[Signature]

Unconfirmed report.



Patient Name	: ABDILLAH MUTTAQIN, SDR	Patient ID	: SHBP.00188858
Sex / Age	: M / 029Yrs	Accession No.	: 10000001426631
Modality	: CR	Scan Date	: 16-04-2019
Procedure	: THORAX AP/PA	Report Date/Time	: 16-04-2019 09:31:19
Ref. Department	: MCU	Referring Physician	: dr. Emilia Saminoe

XR- Thorax PA/ AP view

Technique:

Findings:

PARU: Normal
MEDIASTINUM: Normal
TRAKEA DAN BRONKUS: Normal
HILUS: Normal
EURA: Normal
AFRAGMA: Normal
JANTUNG: Normal CTR: <50%
AORTA: Normal
VERTEBRA THORAKAL DAN TULANG-TULANG LAINNYA: Normal
JARINGAN LUNAK: Normal
ABDOMEN YANG TERVISUALISASI: Normal
LEHER YANG TERVISUALISASI: Normal

Impression:

Tidak tampak kelainan signifikan pada pemeriksaan ini.


dr. Santoso Suhendro, Sp. Rad (K)

This document is digitally signed and hence no manual signature is required.

Patient Name	: ABDILLAH MUTTAQIN, SDR	Patient ID	: SHBP.00188858
Sex / Age	: M / 029Yrs	Accession No.	: 10000001426636
Modality	: US	Scan Date	: 16-04-2019
Procedure	: COMPLETE ABDOMEN USG	Report Date/Time	: 16-04-2019 09:43:04
Ref. Department	: MCU	Referring Physician	: dr. Emilia Saminoe

US- Abdomen and Pelvis, Male

Technique:

Findings:

HEPAR: Normal
LIEN: Normal
SISTEM VENA PORTA: Normal
VENA CAVA INFERIOR, VENA HEPATIKA: Normal
STEM BILIER: Normal
KANTUNG EMPEDU: Normal
PANKREAS: Normal
GINJAL:
• KANAN: Normal
• KIRI: Normal
SISTEM PELVIKALISES: Normal
BULI-BULI: Normal
KELONJAR GETAH BENING: Tidak tampak membesar
CAIRAN BEBAS: Tidak ditemukan
PROSTAT: Normal
VESIKULA SEMINALIS: Normal

Impression:

Pria, 29 Thn pro MCU pada USG Whole Abdomen :

Tidak diketemukan adanya kelainan yg significans


dr. Santoso Suhendro, Sp. Rad (K)

This document is digitally signed and hence no manual signature is required.

LAPORAN TREADMILL EXERCISE TEST
(PROTOKOL BRUCE)

Nama : Sdr. Abdillah Muttaqin Tanggal Treadmill : 16 April 2019
Umur : 29 thn Berat : 52 kg
Jenis Kelamin : Laki - laki Tinggi : 169 cm
Perusahaan : PT. Inspektindo Tekanan Darah Awal : 121/80 mmHg

- ❖ Lama test : 14 Menit 55 Detik
- ❖ Denyut Jantung maksimal : 171 x/menit (*80% MHR*)
- ❖ Tekanan darah maksimal : 204/81 mmHg
- ❖ Test dihentikan karena :
 - Fatigue
 - Dyspnoe
 - Angina
 - Pusing
 - Terdapat perubahan segmen ST - T
 - Target denyut jantung tercapai
- ❖ Perubahan segmen ST - T
 - Upsloping
 - ST depresi 0,5 - 1 mms
 - Bermakna (ST depresi > 1 mm)
 - Tidak terdapat perubahan

Kapasitas Aerobik : 17.30 METS

- ❖ Tingkat kebugaran jasmani :
 - Rendah
 - Kurang
 - Sedang
 - Baik
 - Sangat baik

- ❖ Response Tekanan darah :
 - Normal
 - Response hipertensif

KESIMPULAN:

- Response ischemic positive
- Response ischemic negative
- Borderline stress test
- Indeterminate (Target denyut jantung tidak tercapai)
- FTT UNFIT to work in remote area

Advice :

1 _____
2 _____

Dokter Pemeriksa

Dr. Christiani Muljono, Sp. JP
Siloam Hospitals Balikpapan

dr. Abdillah Mutaqin, PT, Inspektando

Patient ID 188858

6.04.2019 Male 169 cm 52 Kg

5:02:13 29yrs Asian

Meds:

Test Reason:
Medical History: Merokok, stop fatigue

Ref. MD: Ordering MD:
Technician: Firdi Test Type:
Comment:

BRUCE: Total Exercise Time 14:55
Max HR: 171 bpm 89% of max predicted 191 bpm HR at rest: 71
Max BP: 204/81 mmHg BP at rest: 121/80 Max RPP: 344/6 mmHg*bpm
Maximum Workload: 17.30 METS
Max. ST: -0.60 mm, 0.00 mV/s in III; EXERCISE STAGE 4 10:59
Arrhythmia: A:38, PVC:1, PCAP:1
ST/HR index: 0.05 μ V/bpm
HR reserve used: 83 %
HR recovery: 28 bpm
Freq. VE recovery: 0 VE/min
ST/HR hysteresis: -0.006 mV (V/6)
QRS duration: BASELINE: 84 ms, PEAK EX: 78 ms, REC: 84 ms
Location Number: * 0 *

Phase Name	Stage Name	Time in Stage	Speed (km/h)	Grade (%)	Workload (METS)	HR (bpm)	BP (mmHg)	RPP (mmHg*bpm)	VE (l/min)	STLevel (III mm)	Comment
PRETEST	SUPINE	00:01			1.0	71			0	1.50	
	STANDING	00:36	0.00	0.00	1.0	78	121/80	9438	0	1.35	
	HYPERV.	00:01	0.00	0.00	1.0	79			0	1.35	
	WARM-UP	00:51	1.60	0.00	1.5	79	128/74	10112	0	1.60	
	STAGE 1	03:00	2.70	10.00	4.6	88	123/55	10824	0	1.30	
EXERCISE	STAGE 2	03:00	4.00	12.00	7.0	98	135/67	13230	0	0.85	
	STAGE 3	03:00	5.40	14.00	10.0	114	144/70	16416	1	0.10	
	STAGE 4	03:00	6.70	16.00	13.3	150	172/80	25800	0	-0.30	
	STAGE 5	02:55	7.90	18.00	16.9	171	204/81	34884	0	-0.05	
	RECOVERY		03:06	1.50	0.00	1.7	111	156/69	17316	0	0.25

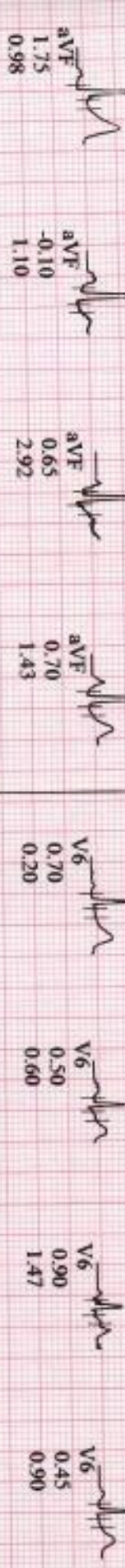
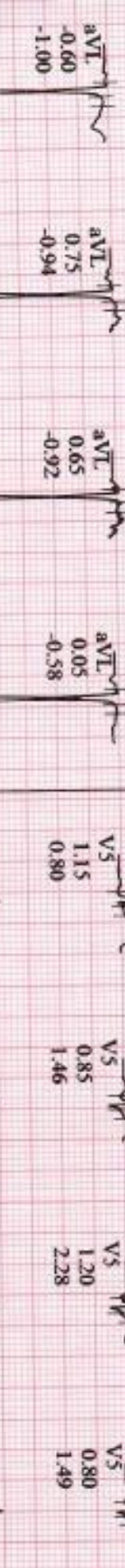
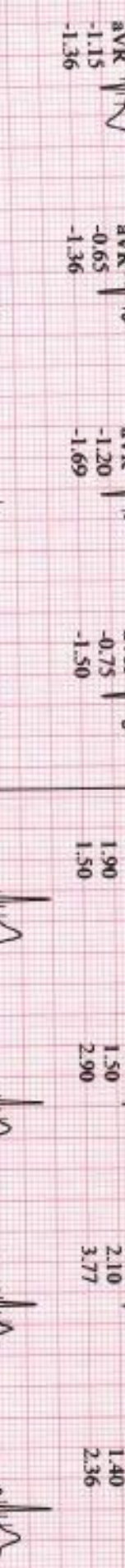
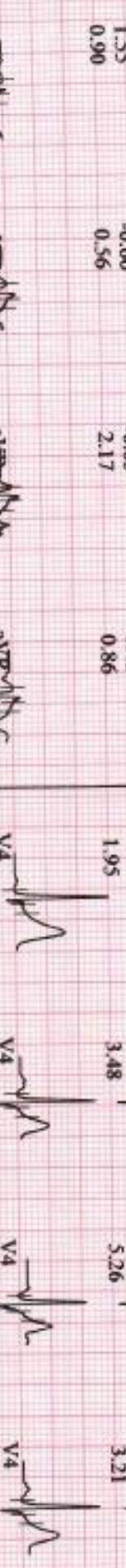
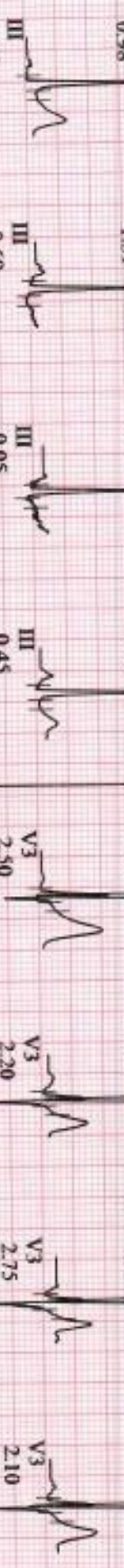
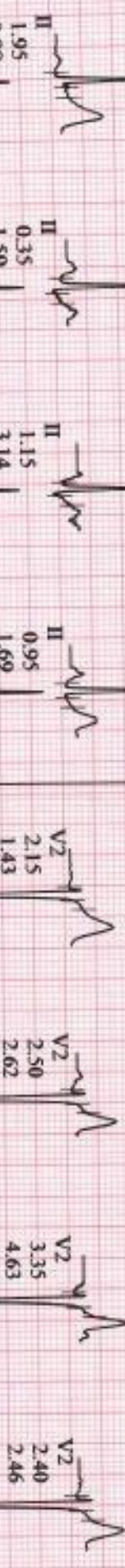
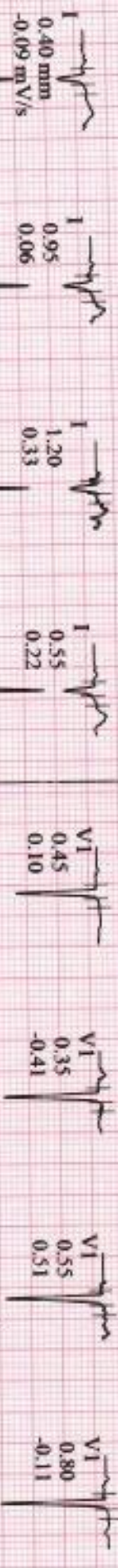
Sdr. Abdullah Murtazaqin, PT. Inspektindo

Patient ID 188858

16.04.2019

15:02:13

BASELINE EXERCISE	MAX. ST EXERCISE	PEAK EXERCISE EXERCISE	TEST END RECOVERY	BASELINE EXERCISE	MAX. ST EXERCISE	PEAK EXERCISE EXERCISE	TEST END RECOVERY
0:00	10:59	14:55	3:04	0:00	10:59	14:55	3:04
80 bpm	142 bpm	171 bpm	111 bpm	80 bpm	142 bpm	171 bpm	111 bpm
128/74 mmHg		204/81 mmHg	156/69 mmHg	128/74 mmHg		204/81 mmHg	156/69 mmHg



GE CASE V6.73 (0)
10mm/mV 50Hz 0.01Hz FRF+ HEART V5.4

Unclassified

Attending MD

12-LEAD REPORT

Siloam Hospital Bahikpapan

Sdr. Abdullah Muttaqin PT. Inspektindo
Patient ID: 188858
16.04.2019
15:02:50

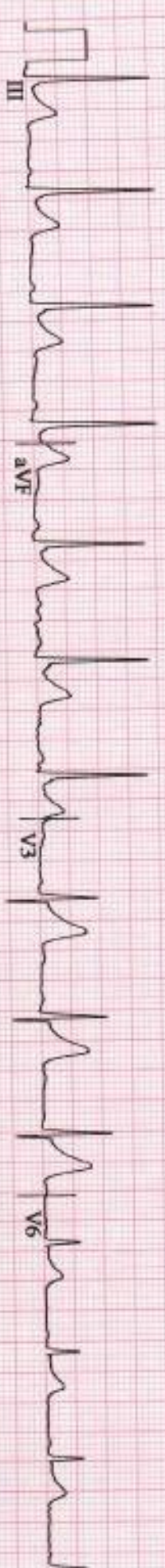
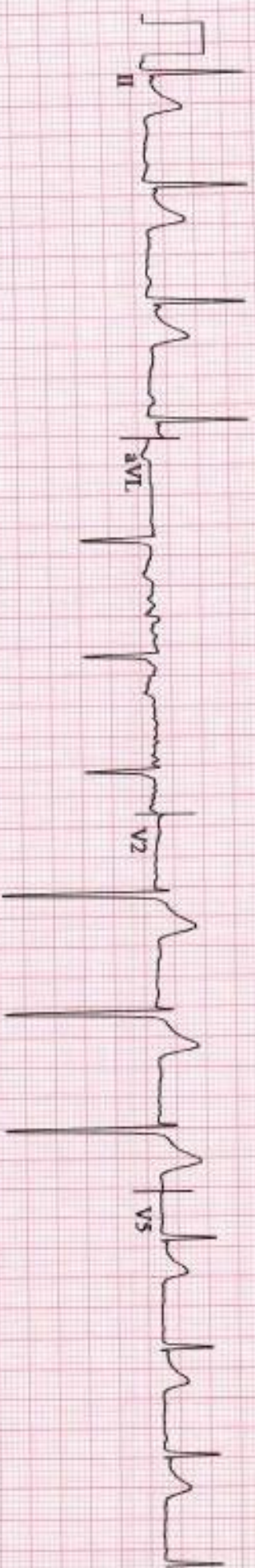
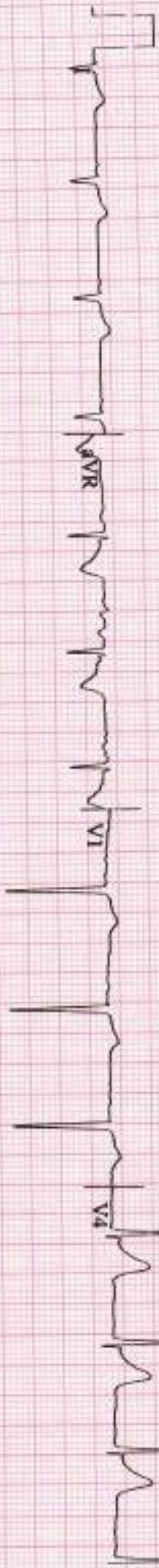
78 bpm
121 80 mmHg

PRETEST
STANDING
00:35

BRUCE
0.0 km/h
0.0 %

Measured at 60ms Post J (10mm mV)
Auto Points

Lead	ST(mV)	Lead	ST(mV)
I	0.45	V1	0.60
II	2.00	V2	2.20
III	1.50	V3	2.45
aVR	-1.25	V4	1.85
aVL	-0.55	V5	1.15
aVF	1.75	V6	0.65



12-LEAD REPORT

79 bpm
 128.74 mmHg

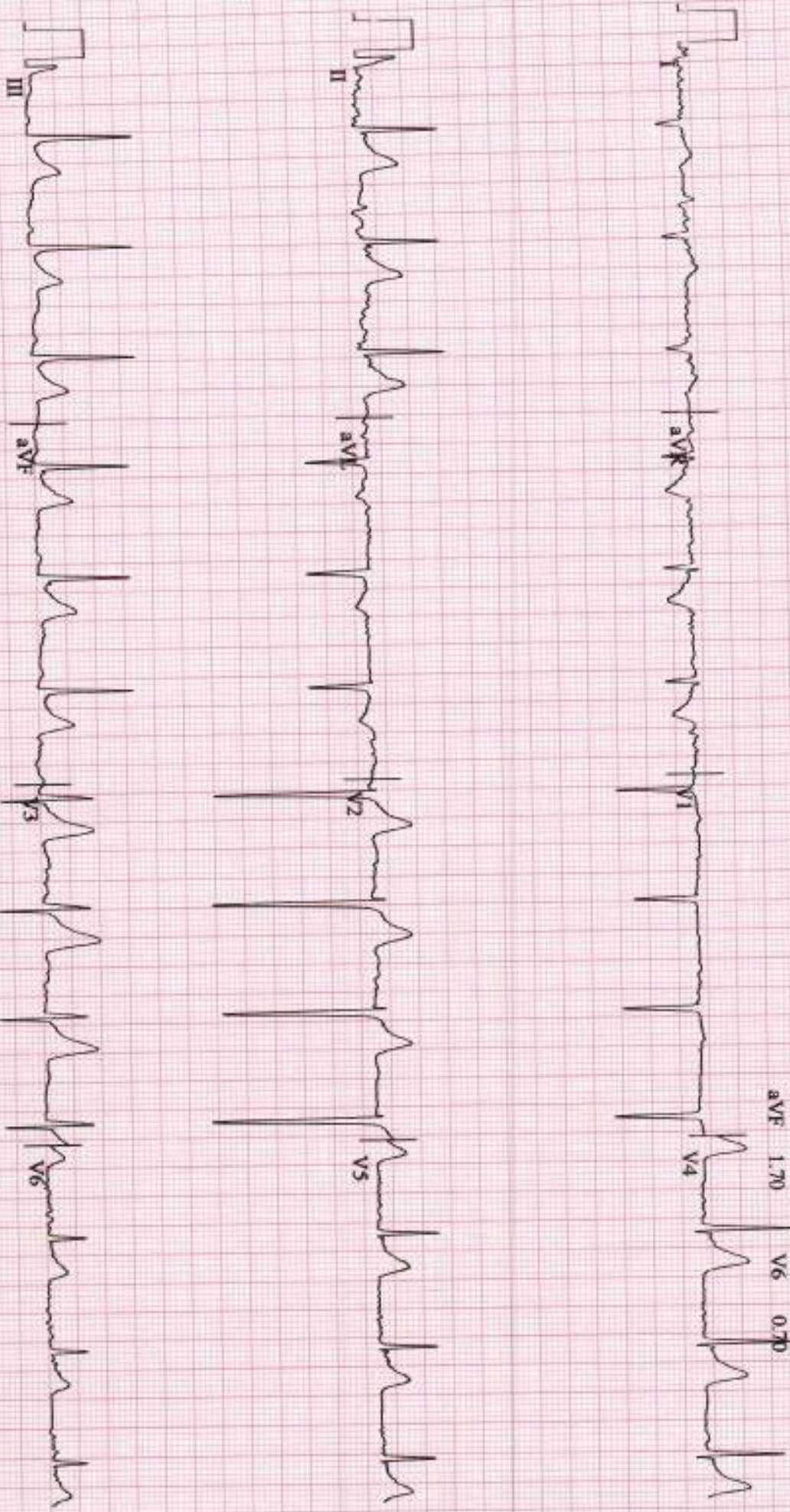
PRETEST
 WARM-UP
 01:25

BRUCE
 1.6 km/h
 0.0%

Siloam Hospital Balikpapan

Measured at 60ms Post J (10mm/mV)
 Auto Points

Lead	ST(mV)	Lead	ST(mV)
I	0.40	V1	0.50
II	1.90	V2	2.10
III	1.50	V3	2.50
aVR	-1.10	V4	1.90
aVL	-0.55	V5	1.15
aVF	1.70	V6	0.70



12-LEAD REPORT

Siloam Hospital Balikpapan

Measured at 60ms Post J (10mm mV)

Auto Points

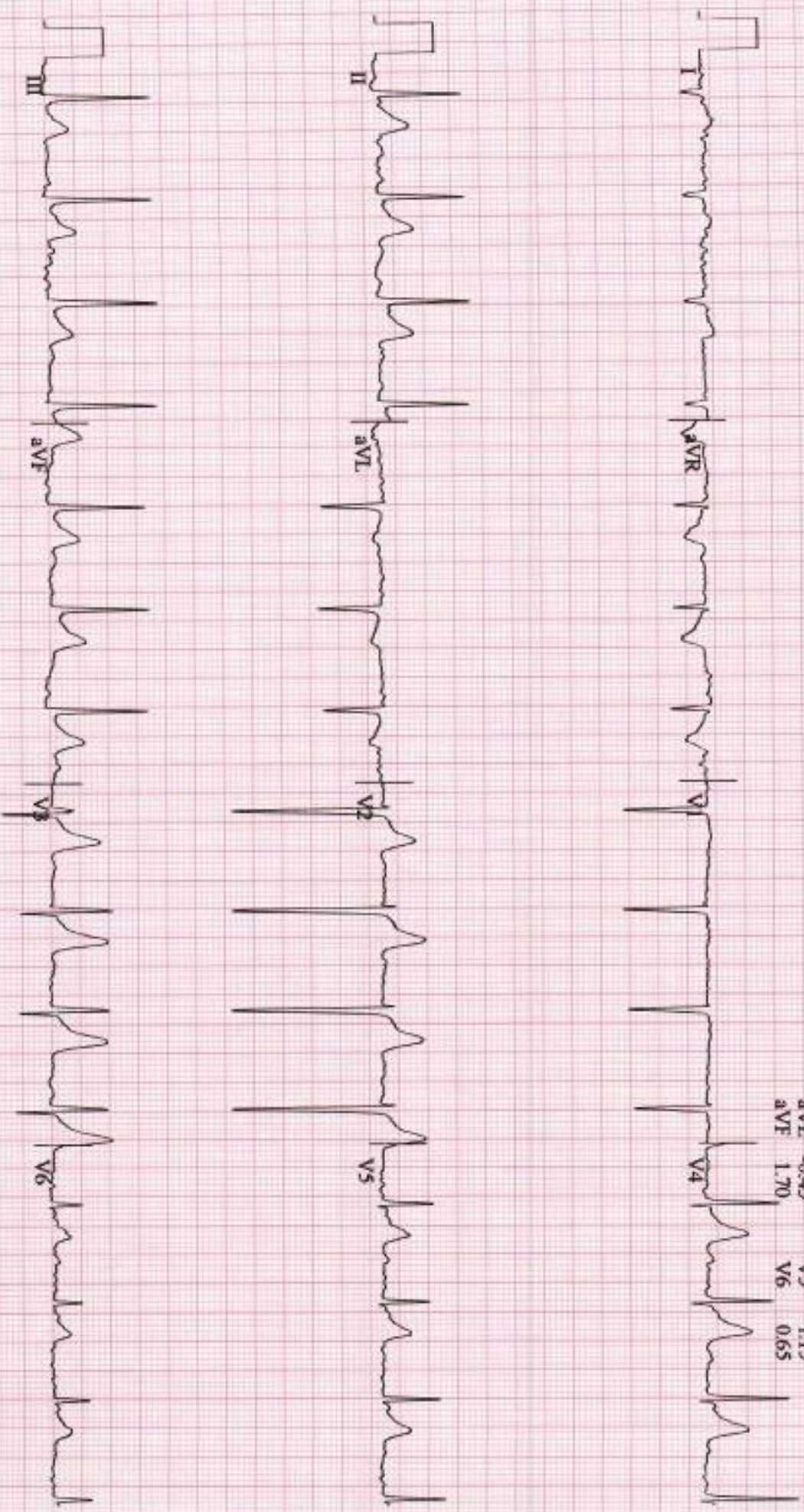
Lead ST(mm) Lead ST(mm)

I	0.50	V1	0.55
II	1.95	V2	2.20
III	1.45	V3	2.50
aVR	-1.25	V4	1.85
aVL	-0.45	V5	1.15
aVF	1.70	V6	0.65

85 bpm
123.55 mmHg

EXERCISE STAGE 1
02:50
BRUCE 2.7 km/h
10.0 %

Sdr. Abdillah Mutaqin PT. Inspektindo
Patient ID: 188858
16.04.2019
15:06:33



GE CASE V673 25 mm/s 10 mm/mV 50Hz 0.01Hz FRF+ HR(V2II)

Start of Test: 15:02:13

12-LEAD REPORT

Siloam Hospital Balikpapan

Sdr. Abdullah Mutraqi PT. Inspektindo
Patient ID: 188858
16.04.2019
15:09:33

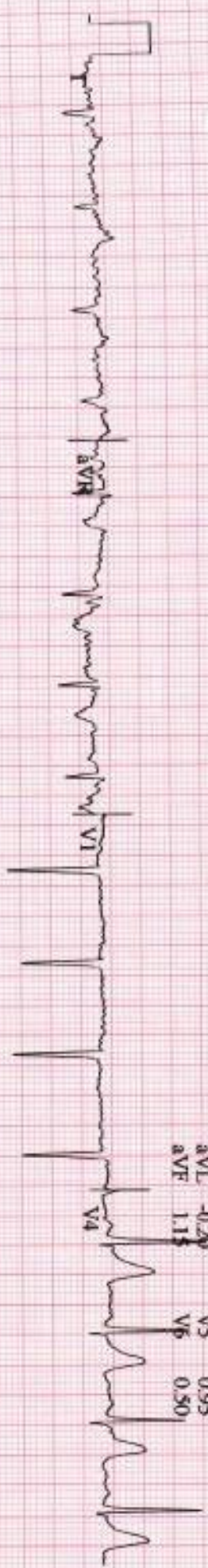
96 bpm
135.67 mmHg

EXERCISE
STAGE 2
05:50

BRUCE
4.0 km/h
12.0 °

Measured at 60ms Post J (10mm mV)
Auto Points

Lead	ST(mV)	Lead	ST(mV)
I	0.45	V1	0.45
II	1.40	V2	2.00
III	0.90	V3	2.30
aVR	-0.95	V4	1.65
aVL	-0.20	V5	0.95
aVF	1.15	V6	0.50



12-LEAD REPORT

Siloam Hospital Bahikpapan

Measured at 60ms Post J (10mm/mV)

Auto Points

Lead ST(mm) Lead ST(mm)

I	0.25	V1	0.40
II	0.55	V2	1.75
III	0.35	V3	2.00
aVR	-0.40	V4	1.40
aVL	0.00	V5	0.75
aVF	0.45	V6	0.25

EXERCISE

STAGE 3

08:50

BRUCE

5.4 km/h

14.0 %

113 bpm

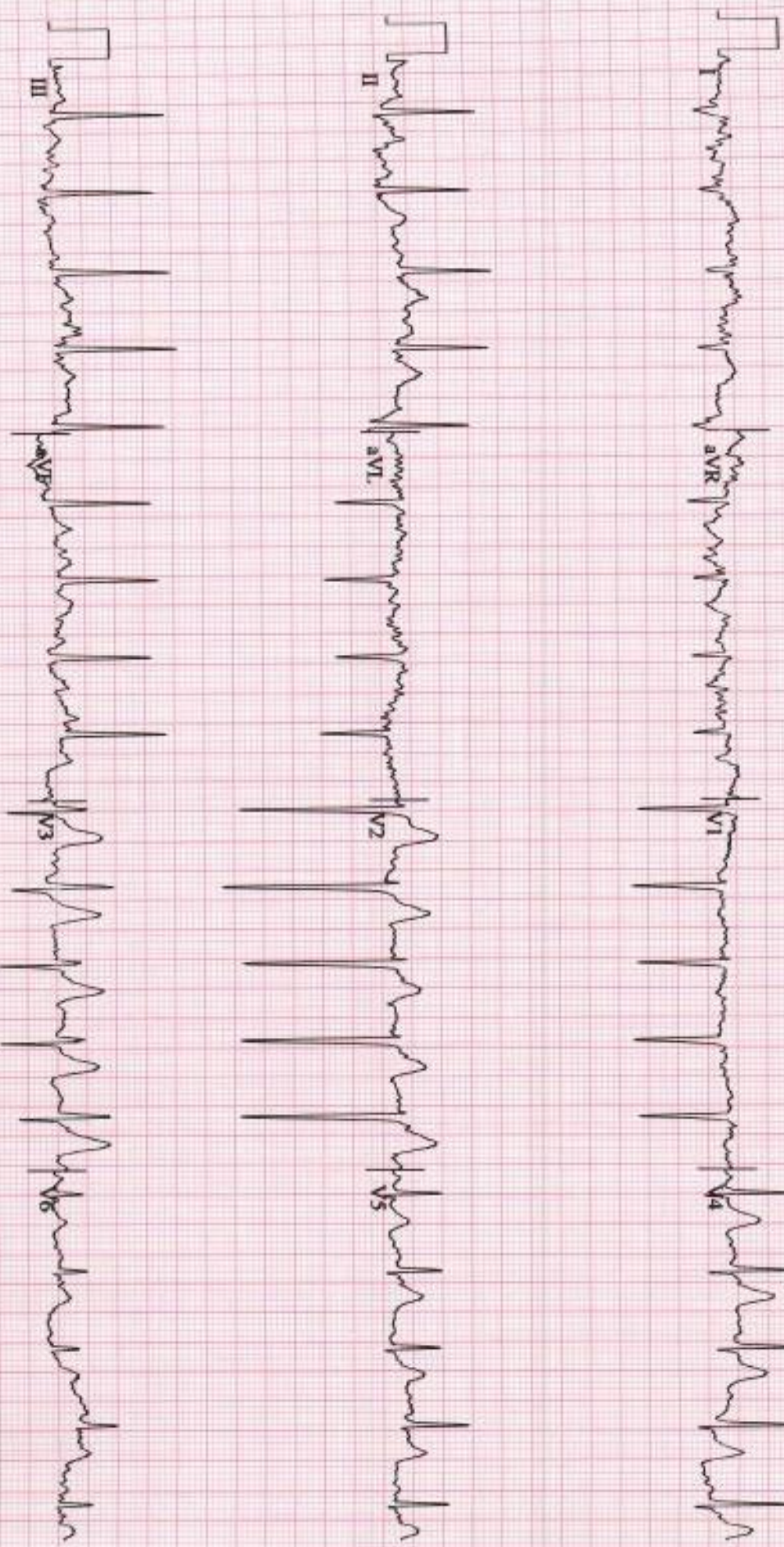
144.70 mmHg

Sdr. Abdillah Murtiqin PT. Inspektando

Patient ID: 188858

16.04.2019

15:12:33



GE CASE V673 25 mm/s 10 mm/mV 50Hz 0.01Hz FRF + HR(II, V2)

Start of Test: 15:02:13

12-LEAD REPORT

Siloam Hospital Bakirkoyan

Sdr. Abdillah Murtadin PT. Inspektindo
Patient ID: 188858

16-04-2019
13:15:33

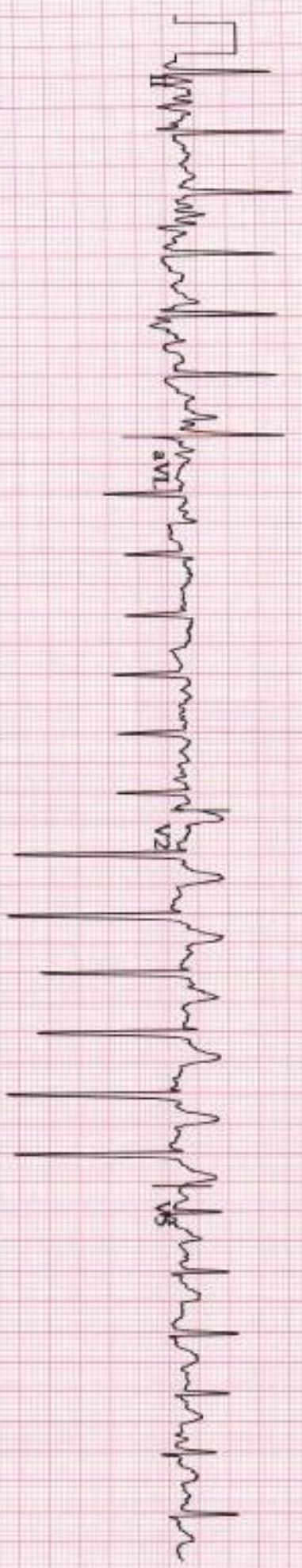
150 bpm
172.80 mmHg

EXERCISE
STAGE 4
11:50

BRUCE
6.7 km/h
16.0 %

Measured at 60ms Post J (10mm/mV)
Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	0.45	V1	0.45
II	0.50	V2	2.45
III	0.00	V3	2.15
aVR	-0.45	V4	1.45
aVL	0.25	V5	0.95
aVF	0.25	V6	0.65



GE
CASE V6.73 25 mm/s 10 mm/mV 50Hz 0.01Hz FRF+ HR(V2II)

Start of Test: 15:02:13

12-LEAD REPORT

Siloam Hospital Bakirkapapan

Measured at 60ms Post J (10mm/mV)

Auto Points

Lead ST(mm) Lead ST(mm)

I	1.50	V1	0.55
II	1.00	V2	3.50
III	-0.50	V3	3.05
aVR	-1.25	V4	2.30
aVL	1.10	V5	1.65
aVF	0.30	V6	1.85

EXERCISE STAGE 5 14:50

BRUCE 8.0 km/h 18.0%

Sdr. Abdullah Murtadin P.T. Inspektindo
Patient ID: 188858
16.04.2019
15:18:33



GE CASE V6:73 25 mm/s 10 mm/mV SOHZ 0.01Hz FRF+ HR(V1,V2)

Start of Test: 15:02:13

12-LEAD REPORT

Siloam Hospital Balikpapan

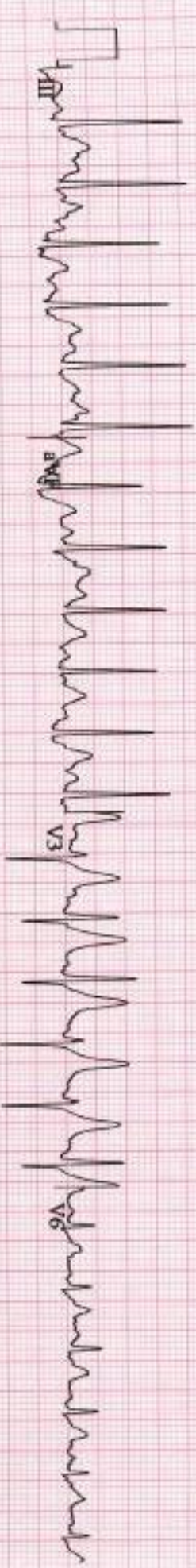
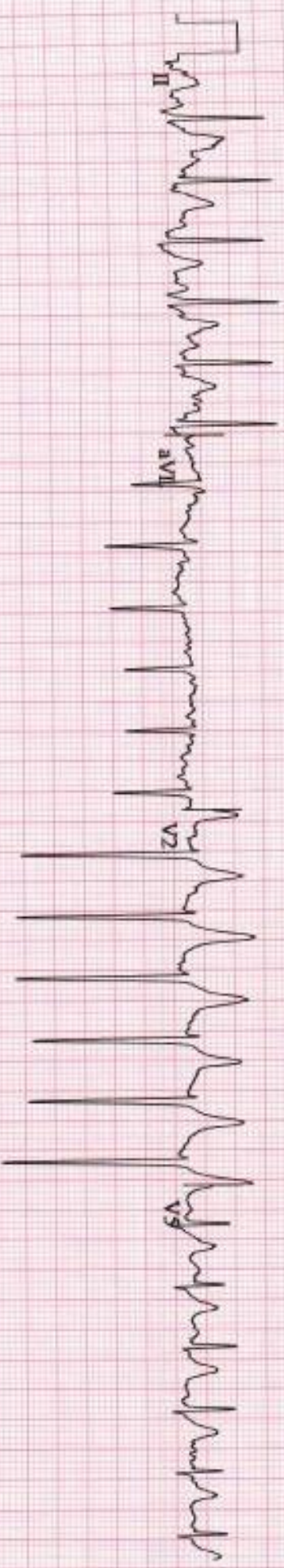
Sdr. Abdillah Murtaqin PT. Inspektindo
Patient ID: 188858
16.04.2019
15:19:28

148 bpm
180.67 mmHg

RECOVERY #1
00:50
BRUCE
2.4 km/h
0.0%

Measured at 60ms Post J (10mm mV)
Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	1.15	V1	0.40
II	1.75	V2	3.80
III	0.65	V3	3.70
aVR	-1.50	V4	2.40
aVL	0.25	V5	1.25
aVF	1.15	V6	0.60



GE
CASE V6.73
25 mm/s 10 mm/mV 50Hz 0.01Hz FRT+ HR(V1,V2)

Start of Test 15:02:13

12-LEAD REPORT

Siloam Hospital Balikpapan

Sdr. Abdillah Muhsin P.T. Inspektindo
Patient ID: 188858
16.04.2019
15.20.28

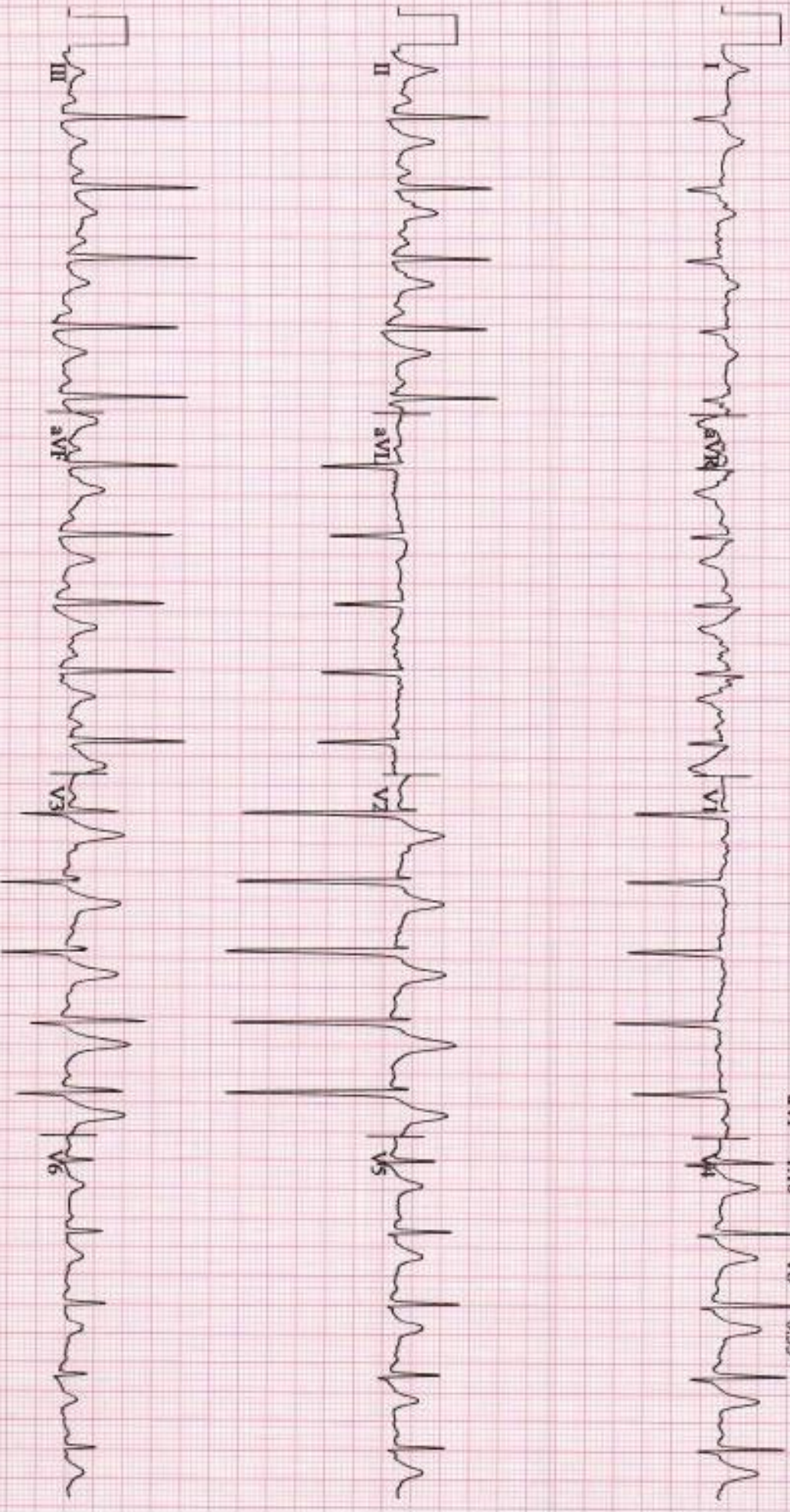
125 bpm

RECOVERY #1
01:50

BRUCE
2.4 km/h
0.0 %

Measured at 60ms Post J (10mm/mV)
Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	0.85	V1	0.70
II	1.50	V2	3.40
III	0.70	V3	3.00
aVR	-1.20	V4	1.95
aVL	0.10	V5	1.15
aVF	1.10	V6	0.55



GE
CASE V6.73
25 mm/s 10 mm/mV 50Hz 0.01Hz FR+ HR(V1,V2)

Start of Test: 15:02:13

Sdr. Abdillah Murtazaqin PT. Inspektando
 Patient ID: 188838
 16.04.2019
 15.21.28

12-LEAD REPORT

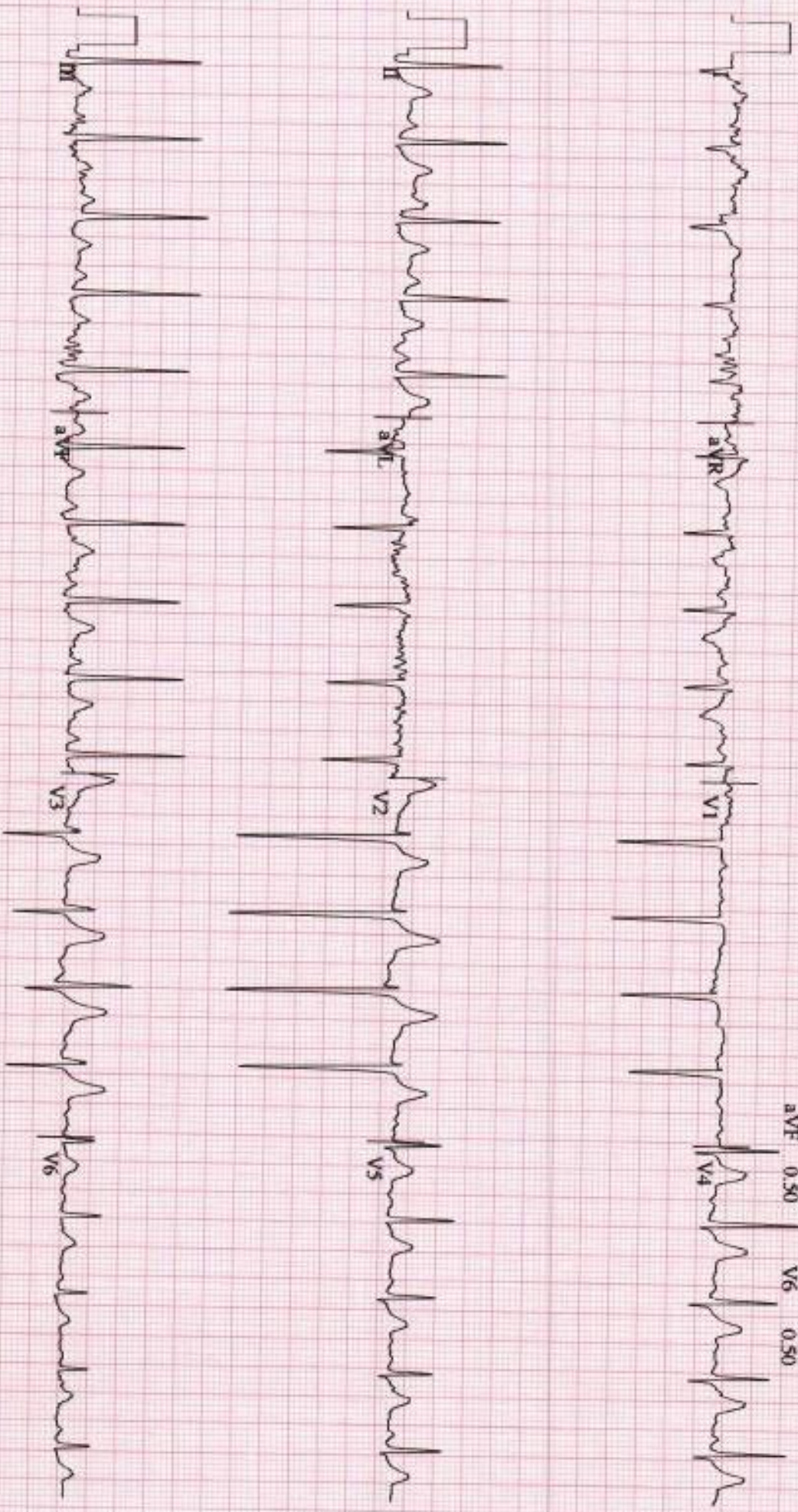
113 bpm
 156.69 mmHg

RECOVERY
 #1
 02:50

BRUCE
 2.4 km/h
 0.0 %

Siloam Hospital Balikpapan
 Measured at 60ms Post J (10mm/mV)
 Auto Points

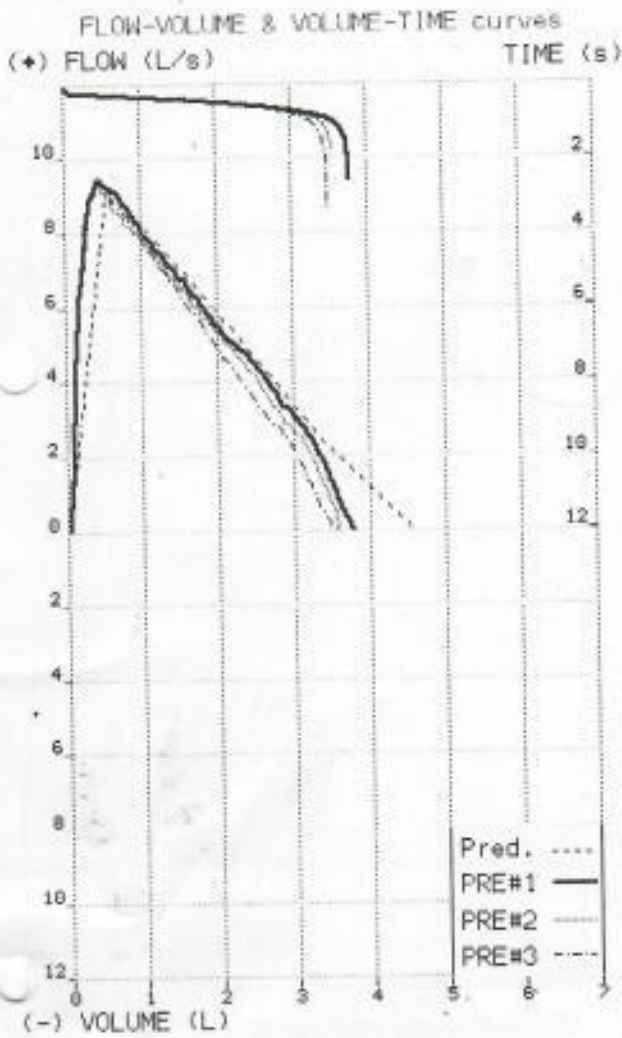
Lead	ST(mV)	Lead	ST(mV)
I	0.45	V1	1.00
II	0.75	V2	2.45
III	0.30	V3	2.20
aVR	-0.55	V4	1.45
aVL	0.10	V5	0.85
aVF	0.50	V6	0.50



GE
 CASE V6.73
 25 mm/s, 10 mm/mV, 50Hz, 0.01Hz, FRF+, HR(V1,V2)

Start of Test: 15:02:13

TEST DATE 16/04/19 10:41 BIPS 1.092 ATS/ERS
 NAME Tn. Abdillah ISP
 BIRTH DATE 20/12/1989 #ID 188858
 AGE 29 HEIGHT cm 169 WEIGHT Kg 52 SEX ♂
 PRE File N° 1029 PREDICTED ERS



BEST VALUES

	Pred.	MEASURED	%Pred
FVC	4.64	3.76	81
FEV1	3.94	3.65	93
FEV1/FVC	82.0	97.0	118
PEF	9.28	9.49	102
FEF2575	4.73	5.67	120

PARAMETER		Pred.	PRE#1	%Pred	PRE#2	PRE#3
VC	L	4.85	3.53	73		
FVC	L	4.64	3.76	81	3.57	3.51
FEV1	L	3.94	3.65	93	3.51	3.37
FEV1/VC	%	82.0	103.4	126	99.4	95.5
FEV1/FVC	%	82.0	97.1	118	98.3	96.0
FEV6	L	4.64	3.76	81	3.57	3.51
FEV1/FEV6	%	84.9	97.1	114	98.3	96.0
PEF	L/s	9.28	9.43	102	9.24	9.49
FEF2575	L/s	4.73	5.67	120	5.84	5.27
FEV3	L	4.41	3.76	85	3.57	3.49
FEV3/FVC	%	95.0	100.0	105	100.0	99.4