Active Employee Medical Checklist

☐Medical Authorization and Release Form

☐Physical Exam Record Form

☐Medical Questionnaire Form

☐Cardiac Risk Factors Form

☐Audiometric/Hearing Exam Results

☐EKG (electrocardiogram) For Persons Age 40 and over *or* History of Cardiac Issues

☐Blood Work Results

☐Urinalysis (not drug test) Results

☐Drug Test (see Drug Testing Information)

☐Copy of Official Vaccinations Record *or* Blood Work Showing Active Immunity

☐Chest X-ray Written Interpretation *only required if not already on file*

☐Blood Type & Rh Factor

Drug Testing Information

- All employees working on expatriate assignments are required to submit a specimen (either: urine, blood, saliva, hair) for laboratory based drug testing.

- Testing must be laboratory based for both screen and, if necessary, confirmation. Testing with handwritten results will not be accepted. Laboratory print out only.

- Results will not be accepted if they are more than 30 days old at the time of submission.

- When testing in the U.S. the testing must include at minimum a five panel non-DOT test.

    - Amphetamine (including Methamphetamine)
    - Cocaine Metabolites
    - Marijuana Metabolites
    - Opiates (including Codeine, Morphine, and Heroin)
    - Phencyclidine

- Outside of the U.S. testing will, at minimum, consist of testing for Marijuana and Cocaine. It is preferred that at least a five (5) panel test be administered wherever possible.

- All non-negative drug screens must be forwarded to a certified laboratory for confirmatory analysis (SAMHSA in the U.S.).

Mobilization Medical Evaluation Information

Per KBR International HR policy, you are required to undergo a fitness for duty medical evaluation while on an expatriate assignment every two years. You may visit your personal physician or the health care facility of your choice to have this medical evaluation done. KBR does not have preferred health care facilities nor does KBR maintain a list of facilities located globally. If you are having difficulty finding a health care facility on your own, you may contact International SOS (ISOS) for assistance. Please reference KBR's membership #: 11BCPA000105.

If calling from:	Call Assistance Center in:	At this number:
U.S. or Canada	Philadelphia, PA	1-800-523-6586 Call collect: 1-215-942-8226
Mexico or South and Central America	Philadelphia, PA	Call collect: 00-1-215-942-8226
Europe, CIS, Africa or the Middle East	London	Call collect: 44-208-762-8008
Asia, Australia or the Pacific Rim	Singapore	Call collect: 65-6338-7800

To avoid delays ensure results and documents are legible and in English. Results may be submitted via email (preferred) to rafael.lopez@kbr.com, fax (713)753-3135 or via postal service to the attention of KBR Medical Office, Rafael Lopez, 601 Jefferson St., Houston, TX 77002.

All medical results and documents are received and stored confidentially in accordance with privacy laws. No part of these results or documents are discussed with anyone other than need to know personnel. Furthermore, details or specifics of results are *not* shared or discussed with HR/Management.

Once all the results, documents, and required proof of vaccinations have been received, the complete chart will be submitted to KBR's Medical Director for final review. After medical clearance has been granted a notification will be sent to HR stating medical clearance and you will be copied.

If you have any question please contact Rafael Lopez, Senior HSSE Medical Specialist at rafael.lopez@kbr.com or (713)753-3817.

KEEP WITH YOUR IMPORTANT TRAVEL DOCUMENTS

International SOS
Medical and Security Services

Membership I.D.
11BCPA000105

Organization
KBR, Inc.

Call our medical and security experts 24/7.
Call for preventative or emergency enquiries.
Call before, during and after travel or assignment.

Bali +62 21 766 4633	**Jakarta** + 62 21 750 6001	**Paris** +33 (0) 155 633 155
Bangkok +66 2 205 7777	**Johannesburg** +27 (0) 11 541 1300	**Philadelphia** +1 215 942 8226
Beijing +86 (0) 10 6462 9100	**Kuala Lumpur** +603 2787 3126	**Phoenix** +1 480 333 3595
Dubai +971 4 601 8777	**London** +44 (0) 20 8762 8008	**Seoul** +82 (2) 3140 1700
Frankfurt +49 6102 3588 100	**Madrid** +34 91 572 4363	**Singapore** +65 6338 7800
Geneva +41 22 785 6464	**Manila** +63 (2) 8687 0909	**Sydney** +61 2 9372 2468
Ho Chi Minh City +84 28 3829 8520	**Moscow** +7495 937 64 77	**Taipei** +886 2 2523 2220
Hong Kong +852 2528 9900	**Mumbai** +91 22 42838383	**Tokyo** +81 3 3560 7183

WHEN DO I USE INTERNATIONAL SOS?

PREPARE
before you leave home:

- Keep your membership card safe and with you at all times
- Call an Assistance Centre for free pretravel information (i.e. vaccination, required medication and travel security concerns)
- Download the Assistance App, log in using your membership number to help you make more informed travel decisions based on our online medical and security reports and country travel risk guides
- Sign up for health and security email alerts
- Inform friends and family that you are with International SOS, so they can get in touch with us should they have any concerns for your welfare while you are away

WHILE ABROAD
all medical and security enquiries, be they of a routine or medical nature:

- Free and unlimited health, safety, and security advice
- Find a local nurse, internationally trained doctor or security specialist near you
- Find medication or medical equipment
- Travel advice on loss of travel documents or legal assistance
- Assistance paying your medical fees

IN AN EMERGENCY
we provide all necessary emergency services, including:

- Arranging medical transportation and care
- Monitoring your condition and provide advice along the way
- Evacuating you when necessary
- Contacting your family, so they know you are in good hands.

WHERE DO I ACCESS MORE INFORMATION?
DOWNLOAD YOUR FREE ASSISTANCE APP

1 **Login** to **internationalsos.com/members** to sign up for health and security email alerts using your membership number or:

2 **Download** the free Assistance App from **app.internationalsos.com** to contact us and help you make more informed travel decisions based on our online medical and security reports and country travel risk guides.

Or scan this code to download from your device's App Store

Access Your Member Portal at internationalsos.com/members

Medical Authorization and Release

I acknowledge that the use of and/or possession of prohibited drugs, including inhalants, and unauthorized alcoholic beverages is a violation of Company policies.

As a condition of employment and further as a condition of performing services for my employer in support of existing contracts; I consent to submit to a physical examination, medical screening, or medical questionnaire(s) as required by my employer. I also give my consent for specimens to be collected from me to be submitted for drug and/or alcohol testing and additional medical testing as required.

I agree that my employment shall be conditional pending the subsequent results of any medical evaluation and substance testing.

Further, I hereby consent to the release of any and all test results to my employer for its use or use by an authorized agent.

I release and agree to hold my employer, and all their officers, directors, employees and agents harmless from any claim or liability which for any reasons the Company is alleged to be legally liable in conjunction with the physical evaluation, or the drug and/or alcohol testing.

Date: ____

Employee Name
(Please Print): ____

Employee Signature: __________________________________

Witness: ____

PHYSICAL EXAMINATION RECORD (To be completed by examining physician)

NAME (*LAST, FIRST, MIDDLE*)	**DATE OF BIRTH** (01JAN1950)	**SAP/EMPLOYEE NUMBER**	
JOB TITLE	**ASSIGNMENT LOCATION**	**Age**	**Sex** ☐M ☐F

VITALS	VISION					Female Only: Pregnancy Test
HT ►	UNCORRECTED		CORRECTED		COLOR VISION	
WT►	Far	Near	Far	Near	☐ Normal	(only if required)
B/P reading(s):	B	B	B	B	☐ Abnormal	☐Negative
	R	R	R	R		☐Positive
	L	L	L	L		
URINALYSIS	(dip results if performed): Protein:		Blood:		Glucose:	

PHYSICAL EXAMINATION► FOR ABNORMAL FINDINGS, √ BOX, MARK (L) OR (R) AND EXPLAIN BELOW

	DESCRIPTION	NORMAL	ABN	COMMENTS
APPEARANCE	Body Build (Note obesity, etc.)			
	Skin (Note scars, location, size)			
EYES	Pupils (Note ERLA)			
	Fundi			
EARS	Canals			
	T.M.'s			
	Gross Hearing			
NOSE	Nostrils/Sinuses			
MOUTH	Throat			
	Teeth			
	Gums			
ENDOCRINE	Lymph Glands			
	Thyroid			
CARDIOVASCULAR	Heart sounds, rhythm, murmur			
PULMONARY	Lung sounds, chest			
ABDOMEN	Inspection			
	Abdominal Masses			
	Hernia/type			
GENITAL (MALES)	Genitalia			
RECTAL	Prostate/Hemorrhoids			
MUSCULOSKELETAL	Full ROM			
LEG VEINS	Varicose (Note severity)			
BREAST				
NEUROLOGICAL	Coordination			
	Motor Function			

☐Needs further evaluation: ______________________________

☐Follow up with personal doctor for: ______________________________

____

Additional Comments: ______________________________

____

____

____

EXAMINER: ______________________________DATE: ______________

(Please Stamp Form)

PHYSICIAN: Please complete and sign below for validation*

Employee/Applicant NAME (*LAST, FIRST, MIDDLE*)	**SAP/EMPLOYEE NUMBER**

JOB DUTIES: Comment on any significant positive or pertinent negative medical findings. Include your opinion as to what, if any, work limitations or workplace modifications are needed to accommodate the examinee. If this is a pre-placement exam, do NOT comment on whether the examinee should be hired.

☐ Medically capable of performing job duties without limitations

☐ Requires limitations or restrictions in job duties that are:

☐Permanent ☐Temporary (expected end date) ___________________

Explain:

DEPLOYMENT READINESS: Comment on any significant medical conditions that require ongoing medical care or that could deteriorate while on assignment and require medical services not available in the assignment location.

Assignment Location: ____

☐ Does not require medical services exceeding the medical capabilities in the assignment location

☐ May require medical services not available in the assignment location (explain)

☐ Requires on going medical services not available in the assignment location (explain)

Will this individual's medical status or medical care requirements change in the next 6 months?

☐ NO ☐YES or POSSIBLY (Explain)

EXAMINER ____ DATE: __________________

(Please stamp form)

MEDICAL QUESTIONNAIRE (completed by employee/applicant)

HR Representative_ ____________________

WBS#____________________

Project and location____________________

DEMOGRAPHIC DATA

Job Title			
Name_______ *(Last)* *(First)* *(Middle)*			
Home Address			
City	State	Postal Code	
Mobile Phone	Other Phone		
E-mail			
Birth Date	Age	Sex M☐ F☐	Height Weight
Personal Physician		Phone #	
Address			
City	State	Postal Code	

ANSWER THE FOLLOWING QUESTIONS COMPLETELY AND ACCURATELY.

WORK & EXPOSURE HISTORY

1)Have you ever worked for KBR and/or Associated Companies?
☐NO ☐YES

2)Are you able to perform the essential functions of your job without changes to specific work tasks, assistive devices or workplace modifications?
☐NO ☐YES (explain what assistance, workplace or job duty changes you require)
____
____

3)Check or list the occupational hazards to which you have been exposed:
☐ Noise ☐ Ionizing Radiation ☐ Lead ☐Mercury ☐Beryllium ☐ Cadmium
☐ Asbestos ☐ Silica Dust ☐ Coal Dust ☐Benzene ☐ H2S
☐ Other: Explain: ____________________
____
☐ None of the above

4)Have you developed any medical condition(s) in connection with your occupation?
(e.g. hearing loss, skin problems, wheezing, backache, blood disease, etc.)
☐NO ☐YES, explain: ____________________
____

5)Have you ever been denied employment for a medical reason?
☐NO ☐YES, explain: ____________________
____
____

6)Have you ever had to leave a job for medical reasons?
☐NO ☐YES, explain: ____________________
____
____

MEDICAL HISTORY

7)Within the last 24 hours have you had:
☐ Fever ☐ Toothache ☐ Cold or flu symptoms ☐ Nausea, vomiting, diarrhea
☐ Other illness____________________
☐ None of the above

8)In the past 12 months have you required any medical or dental care or had any significant changes in your health? ☐NO ☐YES, explain:
____
____

9)Have you ever had cancer: ☐NO ☐YES, explain:
____
____

10)List all of medications you currently take (prescribed or over-the-counter).
____
____

11)List any other medications (prescribed or over the counter) taken in the last 30 days.
____
____

12)FEMALES ONLY - Is there any possibility you may be pregnant or are you trying to get pregnant? ☐ YES ☐ NO
Any gynecological problems? ____________________
____

13)VISION

☐ Poor night vision	☐ Difficulty with depth perception
☐ Blurred vision	☐ Eye allergies or infections
☐ Burning/tearing/redness of eyes	☐ Eye surgery
☐ Cataracts	☐ Glaucoma
☐ Wear glasses/contacts ☐ For reading? ☐ For distance?	☐ Color blindness
Explain	☐ None of the above

14)HEAD, EARS, NOSE

☐ Concussion	☐ Skull fracture	☐ Hearing difficulty
☐ Persistent ringing in ears	☐ Ear surgery	☐ Draining ears
☐ Frequent ear infections	☐ Deafness	☐Vertigo
☐ Frequent Sinus Infections	☐ Eardrum puncture	☐Nose Bleeds
☐ Barotrauma - ear damage due pressure changes (explosion, diving, flying)		
Other		
Explain		☐ None of the above

15)MOUTH & TEETH

☐ Untreated cavities	☐ Broken teeth	☐ Dental implants
☐ Dentures	☐ Other dental appliances	☐ Gingivitis
☐ Other gum disease	☐ Mouth or Throat Cancer	☐ Mouth ulcers
☐ Other dental disease:		
Explain:		☐ None of the above

16)NERVOUS SYSTEM

☐ Epilepsy/Seizures/Convulsions	☐ Head injury or unconsciousness
☐ Stroke	☐ Frequent dizziness
☐ Numbness in arms/hands/legs/feet	☐ Frequent headaches/Migraines
☐ Sudden or increased memory loss	☐ Weakness or paralysis
Explain:	☐ None of the above

17)MENTAL HEALTH

☐ ADD/ADHD	☐ Drug/Alcohol use disorder	☐ Psychosis
☐ PTSD	☐ Anxiety disorder	☐ Depression
☐ Any other mental health or psychological disorder		
Explain:		☐ None of the above

18)CHEST & RESPIRATORY SYSTEM

☐ Allergies/Hay fever	☐ Coughing up phlegm	☐ Pneumonia
☐ Asthma	☐ Frequent colds	☐ Severe sore throat
☐ Broken ribs	☐ Tuberculosis	☐ Shortness of breath
☐ Bronchitis	☐ Spitting up blood	☐ Chronic cough
☐ Night sweats	☐ Wheezing	☐ Sleep apnea
☐ Currently use a CPAP or any other breathing device		
Explain:		☐ None of the above

19)ENDOCRINE

☐ Thyroid disease	☐ Diabetes ☐ Type I ☐ Type II
☐ Pancreatic disease	☐ Parathyroid disorder
☐ Pituitary disorder	☐ Adrenal gland disorder
Explain:	☐ None of the above

20)HEART & CIRCULATORY

☐ High blood pressure	☐ Heart attack/Infarction	☐ High cholesterol
☐ Irregular or rapid heartbeat	☐ Enlarged heart	☐ Heart failure
☐ Arrhythmia requiring treatment	☐ Atrial fibrillation	☐ Pacemaker
☐ Heart valve disease	☐ Stent placement	☐ Heart surgery
☐ Chest pain with exercise	☐ Abnormal EKG	☐ Heart block
☐ Deep vein thrombosis	☐ Varicose veins	☐ Heart murmur
Explain:		☐ None of the above

21)STOMACH / INTESTINAL TRACT

☐ Persistent stomach pain	☐ Excessive gas/Bloating	☐ Black stools
☐ Stomach ulcer	☐ Vomiting/Nausea	☐ Blood in stools
☐ Change in bowel habits	☐ Unexplained weight loss or gain	
☐ Chronic indigestion	☐ Inflammatory bowel disease	☐ Hernia
Explain:		☐ None of the above

22)LIVER

☐ Cirrhosis	☐ Hepatitis	☐ Jaundice	☐ Gall bladder surgery
☐ Portal hypertension	☐ Other		
Explain:			☐ None of the above

23)KIDNEY / BLADDER

☐ Blood in urine	☐ Difficulty starting urination	☐ Kidney stones
☐ Pain with urination	☐ Kidney/Bladder infection	☐ Prostate problems
Other		
Explain:		☐ None of the above

24)BLOOD & CLOTTING CONDITIONS

☐ Anemia (low blood)	☐ Leukemia	☐ Sickle cell disease
☐ Clotting disorders	☐ Immune deficiency	☐ Hard to stop bleeding
☐ Bleeding of gums	☐ Easier than usual bruising	☐ Blood transfusions
Explain:		☐ None of the above

25)MUSCULOSKELETAL

☐ Arthritis/Gout/Rheumatism	☐ Joint swelling
☐ Back injury	☐ Knee problems
☐ Back pain	☐ Neck pain/Whiplash
☐ Back surgery	☐ Broken bones
Explain:	☐ None of the above

26)SKIN

☐ Skin cancer	☐ Skin rashes	☐ Skin discolorations
☐ Skin allergies	☐ Psoriasis/Eczema	☐ Cracking/bleeding
☐ Mole / growth on skin	☐ Itching / peeling	☐ Skin infections
Explain:		☐ None of the above

27)ALLERGIES

☐ To foods:__________________	☐ Medication(s):
☐ Other:_____________________	☐ No known allergies

28)TOBACCO, VAPING and ALCOHOL USE

☐ I currently use tobacco
I smoke ___ Cigarettes, ___ Cigars, or ___Pipe bowls per day
I chew tobacco ________ or use ________Snuff per day

☐ I currently use vaping products (check all that apply)
☐ Nicotine oils, ☐ Essential oils ☐ Hemp oils ☐ Other:

☐ I am an ex-tobacco user or vaper *(Check if you have ever smoked as much as 1 cigarette a day, used 1 oz. of tobacco a day or vaped once a day for at least a year.)*

When did you quit? Month: _____ Year: _____

☐ I have never used or only briefly tried tobacco or vaping products

29)ALCOHOL USE	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

Further_explanation:

____
____
____
____
____
____
____
____
____
____
____
____
____
____

Notice: You have received a conditional offer of employment. This medical history statement is required. The answers to the medical history statement and any medical examination will be kept confidential. The job offer, which you have received, is conditioned upon satisfactory completion and review of this medical history statement, any required medical examinations or follow-up and job assignment availability.

Employee Affirmation: I herewith affirm that the employer has made me an offer of employment. The purpose of this inquiry is to determine whether I currently have the physical qualifications necessary to perform the job that has been offered; to determine whether and what accommodations may be necessary; and to determine whether I can perform the job without posing a significant/direct threat to the health and safety of myself or others. This information will be kept confidential in a separate medical file, apart from my personnel file. I hereby affirm that the questions in the medical questionnaire have not been asked of me by anyone with the employer until after I have signed this statement and been offered a conditional job. I certify that the foregoing statements are true to the best of my knowledge. I understand that leaving out or misrepresenting the facts called for in this questionnaire may be the cause for refusal of employment or termination from the company. I hereby authorize the company to investigate the facts claimed by me on this questionnaire.

I hereby grant permission to the examining medical personnel and/or physician to disclose any information herein and hereinafter furnished by me, to authorized company personnel for purposes related to my employment at KBR, and Associated Companies, and to legal entities requiring such information.

I understand that, if applicable, the pre-placement physical examination is not a general physical examination of the type given by a physician to assess the state of my health and it may not be relied upon by me for that purpose.

____
Signature   Date

Atherosclerotic Cardiovascular Disease Risk

ALL REGIONS EXCEPT UK & EUROPE (use Page 2 for UK & EUROPE)

(to be completed by physician)

Employee/Applicant Name:______________________________ Date of Birth:_____________

Does the person have known atherosclerotic cardiovascular disease (exertional angina, prior myocardial infarction, prior embolic stroke, history of stent placement)?

☐ YES – STOP, do not calculate a risk score.

☐ NO, - Enter the information below into the risk estimator at this URL and report the 10-year

ASCVD Risk Score: http://tools.acc.org/ASCVD-Risk-Estimator-Plus/#!/calculate/estimate/

First, select the Units of Measure at the top of the Risk Estimator (US or SI). Then enter this information:

Age _____ **Sex** ☐ Male ☐ Female **Race** ☐ White ☐ African American ☐ Other

Blood Pressure _____/_____(mm Hg)

Total Cholesterol	_____(mg/dl) or _____(mmol/L)		
HDL Cholesterol	_____(mg/dl) or _____(mmol/L)		
LDL Cholesterol	_____(mg/dl) or _____(mmol/L)		
Diabetes?	☐Yes	☐No	
Smoker?	☐Current	☐Former	☐Never
On Hypertension Treatment?	☐Yes	☐No	
On a Statin?	☐Yes	☐No	
On Aspirin Therapy?	☐Yes	☐No	

Current 10-Year ASCVD Risk Score _________%

If the 10-year risk is 15% or higher advise the person to obtain treatment to lower the risk as much as possible.

Physician's signature____ Date___________

UK & EUROPE: Atherosclerotic Cardiovascular Disease Risk

Employee/Applicant Name:______________________________ Date of Birth:_____________

Does the person have known atherosclerotic cardiovascular disease (exertional angina, prior myocardial infarction, prior embolic stroke, history of stent placement)?

☐ YES – STOP, do not calculate a risk score.

☐ NO, - Enter the information below into the risk estimator at this URL and report the 10-year

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ASCVD Risk Score UK and Europe: https://qrisk.org/2017/

Age _____ **Sex** ☐ Male ☐ Female

Ethnicity ☐ White or not stated ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Other Asian ☐ Black Caribbean ☐ Black African ☐ Chinese ☐ Other Ethnic Group

UK Post Code __________ (Leave blank if unknown)

Smoking Status ☐ non-smoker ☐ ex-smoker ☐ Light smoker (less than 10) ☐ Moderate Smoker (20-19) ☐ Heavy Smoker (20 or over)

Diabetes Status ☐ None ☐ Type I ☐ Type II

Angina or heart attack in a 1st degree relative <60? ☐ Yes ☐ No

Chronic kidney disease (stage 4 or 5)? ☐ Yes ☐ No

Atrial Fibrillation? ☐ Yes ☐ No

On blood pressure treatment? ☐ Yes ☐ No

Rheumatoid Arthritis? ☐ Yes ☐ No

Cholesterol HDL Ratio______

Blood Pressure ________/________(mmHg)

Height__________ (cm)

Weight__________(kg)

QRISK® 2-2017 risk score__________

If the 10-year risk is 15% or higher advise the person to obtain treatment to lower the risk as much as possible.

Physician's signature____ Date___________

Blood Work for Active Employees

Complete Blood Count

- ☐WBC (white blood cell count)
- ☐RBC (red blood cell count)
- ☐Hemoglobin
- ☐Hematocrit
- ☐Platelet count
- ☐MCV (mean corpuscular volume)
- ☐MCH (mean corpuscular hemoglobin)
- ☐RDW (red cell distribution width)

Blood Chemistry

- ☐Hemoglobin A1C
- ☐Sodium
- ☐Potassium
- ☐Calcium
- ☐Phosphorus
- ☐Albumin
- ☐Total Protein
- ☐Creatinine + eGFR (estimated glomerular filtration rate)
- ☐Bilirubin

Lipids Profile

- ☐Triglycerides
- ☐LDL (low density lipoprotein) cholesterol
- ☐HDL (high density lipoprotein) cholesterol
- ☐Total cholesterol

- ☐Blood Type and Rh factor

Optional or if clinically indicated

- ☐Blood Glucose (random or fasting)
- ☐Globulin
- ☐A/G Ratio (albumin to globulin)
- ☐Chloride
- ☐CO2
- ☐BUN/Creatinine Ratio
- ☐Uric Acid
- ☐CPK (creatine phosphokinase)
- ☐AST (aspartate amino transferase, also called SGOT)
- ☐GGT (Gamma-glutamyl transferase).
- ☐LDH (lactate dehydrogenase)
- ☐PSA (Prostate-specific antigen) In men > 50 years
- ☐Interferon Gamma Release Assay (QuantiFERON-TB Gold, T-Spot or equivalent)
- ☐ALP (alkaline phosphatase)
- ☐ALT (alanine transaminase, also called SGPT)