

**Health Check up Booking Request(43E1770)**

1 message

**Medsave** <it@medsave.in>  
To: healthcareshridurga@gmail.com  
Cc: customercare@mediwheel.in

7 November 2024 at 18:39



**011-41195959**

Dear **Shri Durga Healthcare**

We have received a booking request with the following details. Provide your confirmation by clicking on the Yes button.

**You confirm this booking?**      Yes      No

**Name** : MRS SUSHILA DEVI  
**Proposal No** : 3245  
**Branch Code** : 112  
**Contact Details** : 9810166950  
**Location** : D63, Har Gyan Singh Arya Marg, South Extension I, Block D,  
New Delhi, Delhi 110049  
**Appointment Date** : 08-11-2024

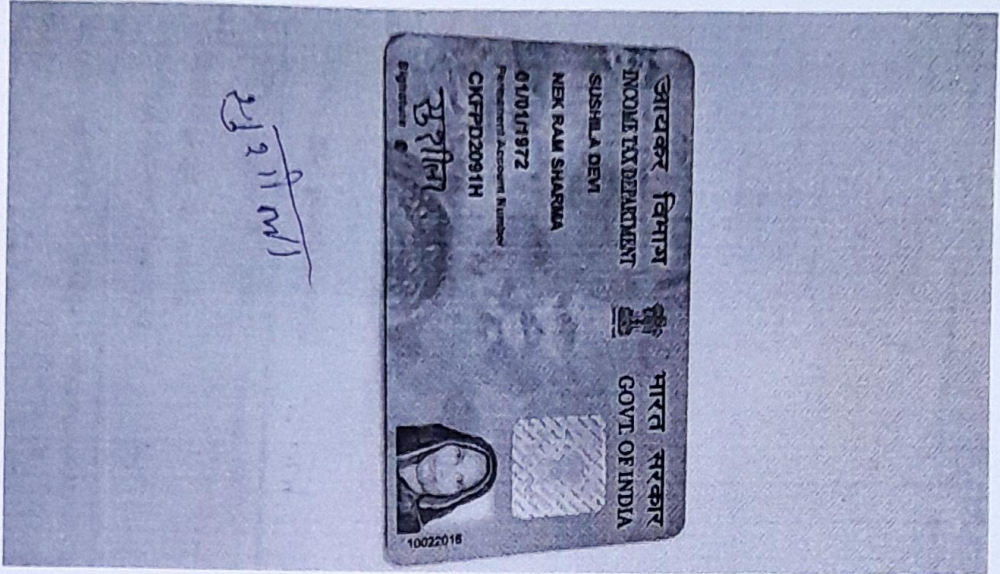
Member Information		
Booked Member Name	Age	Gender
MRS SUSHILA DEVI	52 year	Female

**Included Test -**

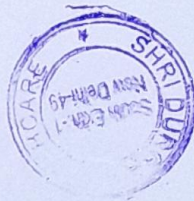
- Urine Analysis
- Hb%
- Lipidogram
- BST Only fasting or Only PGBS
- Physical Medical Examination Report (PMER) Up To Rs. 15,00,000
- ECG

Thanks,  
Medsave  
Team





Dr. PREETI DHIMAN  
M.B.B.S



**IDENTIFICATION & DECLARATION FORMAT**

To,  
LIC of India  
Branch Office

Proposal No : 112 3245

Name of Life to be assured: Sushila Devi

The Life to be assured was identified on the basis of: pan

I have satisfied myself with regard to the identity of the Life to be assured before conducting tests / examination for which report/s are enclosed.

I hereby declare that the person examined has signed (affixed his/her thumb impression) in the space earmarked below, in my presence and I am not related to him/her or the Agent or the Development Officer.

Dated at 21 on the 8/11/24 day of 20 24 at 11:25 a.m./p.m.

Signature of the Pathologist/Doctor: PREETI DHIMAN  
(Name & Rubber stamp) Qualification: M.P.R.S

Signature of the Cardiologist (if LA has undergone CTMT / ECG)  
Name & Rubber stamp) Qualification

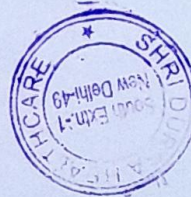
Signature of the Radiologist (if LA has undergone X-ray or scanning)  
Name & Rubber stamp) Qualification

The examinations /tests were done with my consent and I was fasting for more than 12 hrs before the tests

Signature of the Life to be Assured: Sushila Devi  
Name.....

Reports enclosed.

- 1..... PMR
  - 2..... ECG
  - 3..... MBI
  - 4..... lipidogram
  - 5..... RUA
- 6 FBS





**MEDICAL EXAMINER'S REPORT**  
Form No LIC03-001(Revised 2020)

Branch Code: 112  
Proposal/ Policy No: 3245  
MSP name/code: 6018  
Date & Time of Examination: 8/11/24  
Medical Diary No & Page No: 11.30 Am

Mobile No of the Proposer/Life to be assured: \_\_\_\_\_  
Identity Proof verified: Pass ID Proof No. \_\_\_\_\_  
( In Case of Aadhaar Card, please mention only last four digits)

[ Note: Mobile number and identity proof details to be filled in above . For Physical MER, Identity Proof is to be verified and stamped.]

For Tele/ Video MER, consent given below is to be recorded either through email or audio/video message. For Physical Examination the below consent is to be obtained before examination.

"I would like to inform that this call with/ visit to Dr. Pradeep..... (Name of the Medical Examiner) is for conducting your Medical Examination through Tele/ Video/ Physical Examination on behalf of LIC of India".

Signature/ Thumb impression of Life to be assured  
(In case of Physical Examination)

1 Full name of the life to be assured: Sushila Devi  
2 Date of Birth: 01/01/1972 Age: 52 Gender: Female  
3 Height (In cms): 155 Weight (In kgs): 68  
4 Required only in case of Physical MER

Pulse: 66 Blood Pressure (2 readings):  
1. Systolic 126 Diastolic 82  
2. Systolic 126 Diastolic 82

**ASCERTAIN THE FOLLOWING FROM THE PERSON BEING EXAMINED**

If answer/s to any of the following questions is Yes, please give full details and ask life to be assured to submit copies of all treatment papers, investigation reports, histopathology report, discharge card, follow up reports etc. along with the proposal form to the Corporation

- |  |           |
|--|-----------|
| <p>5 a. Whether receiving or ever received any <b>treatment/ medication</b> including alternate medicine like ayurveda, homeopathy etc ?<br/>b. Undergone any <b>surgery / hospitalized</b> for any medical condition / disability / injury due to accident?<br/>c. Whether visited the doctor any time in the last 5 years ?<br/>If answer to any of the questions 5(a) to (c) ) is yes -<br/>i. Date of surgery/accident/injury/hospitalisation<br/>ii. Nature and cause<br/>iii. Name of Medicine<br/>iv. Degree of impairment if any<br/>v. Whether unconscious due to accident, if yes, give duration</p> | <p>No</p> |
| <p>6 In the last 5 years, if advised to undergo an X-ray/ CT scan / MRI / ECG / TMT / Blood test / Sputum/Throat swab test or any other investigatory or <b>diagnostic tests</b>?<br/>Please specify date , reason ,advised by whom &amp; findings.</p>  | <p>No</p> |
| <p>7 Suffering or ever suffered from <b>Novel Coronavirus (Covid-19)</b> or experienced any of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malaise (flu-like tiredness), Rhinorrhea (mucus discharge from the nose), Sore throat, Gastro-intestinal symptoms such as nausea, vomiting and/or diarrhoea, Chills, Repeated shaking with chills, Muscle pain, Headache, Loss of taste or smell within last 14 days.<br/>If yes provide all investigation and treatment reports</p>   | <p>No</p> |



**DR. PREETI DHIMAN**  
M.B.B.S

8	<p>a. Suffering from <b>Hypertension</b> (high blood pressure) or <b>diabetes</b> or blood sugar levels higher than normal or history of sugar /albumin in urine?</p> <p>b. Since when, any follow up and date and value of last checked blood pressure and sugar levels?</p> <p>c. Whether on medication? please give name of the prescribed medicine and dosage</p> <p>d. Whether developed any complications due to diabetes?</p> <p>e. Whether suffering from any other <b>endocrine disorders</b> such as thyroid disorder etc.?</p> <p>f. Any weight gain or weight loss in last 12 months (other than by diet control or exercise)?</p>	NO
9	<p>a. Any history of chest pain, <b>heartattack</b>, palpitations and breathlessness on exertion or irregular heartbeat?</p> <p>b. Whether suffering from <b>high cholesterol</b>?</p> <p>c. Whether on medication for any heart ailment/ high cholesterol? Please state name of the prescribed medicine and dosage.</p> <p>d. Whether undergone Surgery such as CABG, open heart surgery or PTCA?</p>	NO
10	Suffering or ever suffered from any disease related to <b>kidney</b> such as kidney failure, kidney or ureteral stones, blood or pus in urine or prostate?	NO
11	Suffering or ever suffered from any <b>Liver disorders</b> like cirrhosis, hepatitis, jaundice, or disorder of the Spleen or from any <b>lung related</b> or respiratory disorders such as Asthma, bronchitis, wheezing, tuberculosis breathing difficulties etc.?	NO
12	Suffering or ever suffered from any <b>Blood disorder</b> like anaemia, thalassemia or any Circulatory disorder?	NO
13	Suffering or ever suffered from any form of <b>cancer</b> , leukaemia, tumor, cyst or growth of any kind or enlarged lymph nodes?	NO
14	Suffering or ever suffered from Epilepsy, <b>nervous disorder</b> , multiple sclerosis, tremors, numbness, paralysis, brain stroke?	NO
15	Suffering or ever suffered from any <b>physical impairment</b> / disability /amputation or any congenital disease/abnormality or disorder of back, neck, muscle, joints, bones, arthritis or gout?	NO
16	Suffering or ever suffered from Hernia or <b>disorder of the Stomach</b> / intestines, colitis, indigestion, Peptic ulcer, piles, or any other disease of the gall bladder or pancreas?	NO
17	<p>a. Suffering from Depression/Stress/ Anxiety/ Psychosis or any other Mental / <b>psychiatric disorder</b>?</p> <p>b. Whether on treatment or ever taken any treatment, if yes, please give details of treatment, prescribed medicine and dosages</p>	NO NO
18	Is there any <b>abnormality</b> of Eyes (partial/total blindness),Ears (deafness/ discharge from the ears), Nose, Throat or Mouth,teeth, swelling of gums / tongue, tobacco stains or signs of oral cancer?	NO
19	Whether person being examined and/ or his/her spouse/partner tested positive or is/ are under treatment for <b>HIV /AIDS/ Sexually transmitted diseases</b> (e.g. syphilis, gonorrhoea, etc.)	NO
20	Ascertain if any other condition / disease / adverse habit (such as <b>smoking/ tobacco chewing/ consumption of alcohol/drugs</b> etc) which is relevant in assessment of medical risk of examinee.	NO

Dr. PRADEEP DHIMAN  
M.B.B.S.




For Female Proponents only		
i.	Whether pregnant? If so duration.	Yes
ii	Suffering from any pregnancy related complications	No
iii	Whether consulted a gynaecologist or undergone any investigation, treatment for any gynaec ailment such as fibroid, cyst or any disease of the breasts, uterus, cervix or ovaries etc. or taken / taking any treatment for the same	No

FROM MEDICAL EXAMINER'S OBSERVATION/ASSESSMENT WHETHER LIFE TO BE ASSURED APPEARS MENTALLY AND PHYSICALLY HEALTHY	Yes
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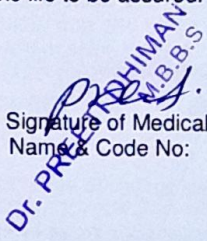
Declaration

You Mr/Ms. Sushila Devi declare that you have fully understood the questions asked to you during the call / Physical Examination and have furnished complete, true and accurate information after fully understanding the same. We thank you for having taken the time to confirm the details. The information provided will be passed on to Life Insurance Corporation of India for further processing.

  
 Signature/ Thumb impression of Life to be assured  
 (In case of Physical Examination)

I hereby certify that I have assessed/ examined the above life to be assured on the \_\_\_ day of \_\_\_ 20\_\_\_ vide Video call / Tele call/ Physical Examination personally and recorded true and correct findings to the aforesaid questions as ascertained from the life to be assured.

Place: MD  
 Date: 08/11/24  
 Stamp:

  
 Signature of Medical Examiner  
 Name & Code No:



**LIFE INSURANCE CORPORATION OF INDIA**

Zone \_\_\_\_\_ Division \_\_\_\_\_ Branch \_\_\_\_\_  
Proposal No. \_\_\_\_\_

Agent/D.O. Code: \_\_\_\_\_

Full Name of Life to be assured: \_\_\_\_\_

Age/Sex \_\_\_\_\_

*Sushila Devi*  
*52/F*

**ELECTROCARDIOGRAM**

**ANNEXURE- 1**

LIC03-002

Instructions to the Cardiologist:

- i. Please satisfy yourself about the identity of the examiners to guard against impersonation
- ii. The examinee and the person introducing him must sign in your presence. Do not use the form signed in advance. Also obtain signatures on ECG tracings.
- iii. The base line must be steady. The tracing must be pasted on a folder.
- iv. Rest ECG should be 12 leads along with Standardization slip, each lead with minimum of 3 complexes, long lead II. If L-III and AVF shows deep Q or T wave change, they should be recorded additionally in deep inspiration. If V1 shows a tall R-Wave, additional lead V4R be recorded.

**DECLARATION**

I hereby declare that the foregoing answers are given by me after fully understanding the questions. They are true and complete and no information has been withheld. I do agree that these will form part of the proposal dated \_\_\_\_\_ given by me to LIC of India.

Witness \_\_\_\_\_

*[Signature]*  
Signature or Thumb Impression of L.A.

**Note :** Cardiologist is requested to explain following questions to L.A. and to note the answers thereof.

- i. Have you ever had chest pain, palpitation, breathlessness at rest or exertion?  
Y/N
- ii. Are you suffering from heart disease, diabetes, high or low Blood Pressure or kidney disease? Y/N
- iii. Have you ever had Chest X- Ray, ECG, Blood Sugar, Cholesterol or any other test done? Y/N

If the answer/s to any/all above questions is -Yes, submit all relevant papers with this form.

Dated at *ND* on the day of *8/11/2024*

*[Signature]*  
Signature of L.A.

*[Signature]*  
Signature of the Cardiologist

*[Stamp]*  
Name & Address  
Qualification

Code No.

Clinical findings  
(A)



Height (Cms)	Weight (kgs)	Blood Pressure	Pulse Rate
155	68	126/82	66

(B) Cardiovascular System

NAD

Rest ECG Report:

Position	Sup.	P Wave	Normal
Standardisation Imv	10k	PR Interval	Normal
Mechanism	Normal	QRS Complexes	Normal
Voltage	Normal	Q-T Duration	Normal
Electrical Axis	Normal	S-T Segment	Normal
Auricular Rate	60L	T-wave	Normal
Ventricular Rate	60L	Q-Wave	Normal
Rhythm	Sinus		
Additional findings, if any.	NO		

Conclusion:

LO NL

Dated at

20 8/11/24 2024

on the day of

2024

Signature of the Cardiologist

Name & Address

Qualification

Code No.





# SHRI DURGA HEALTH CARE

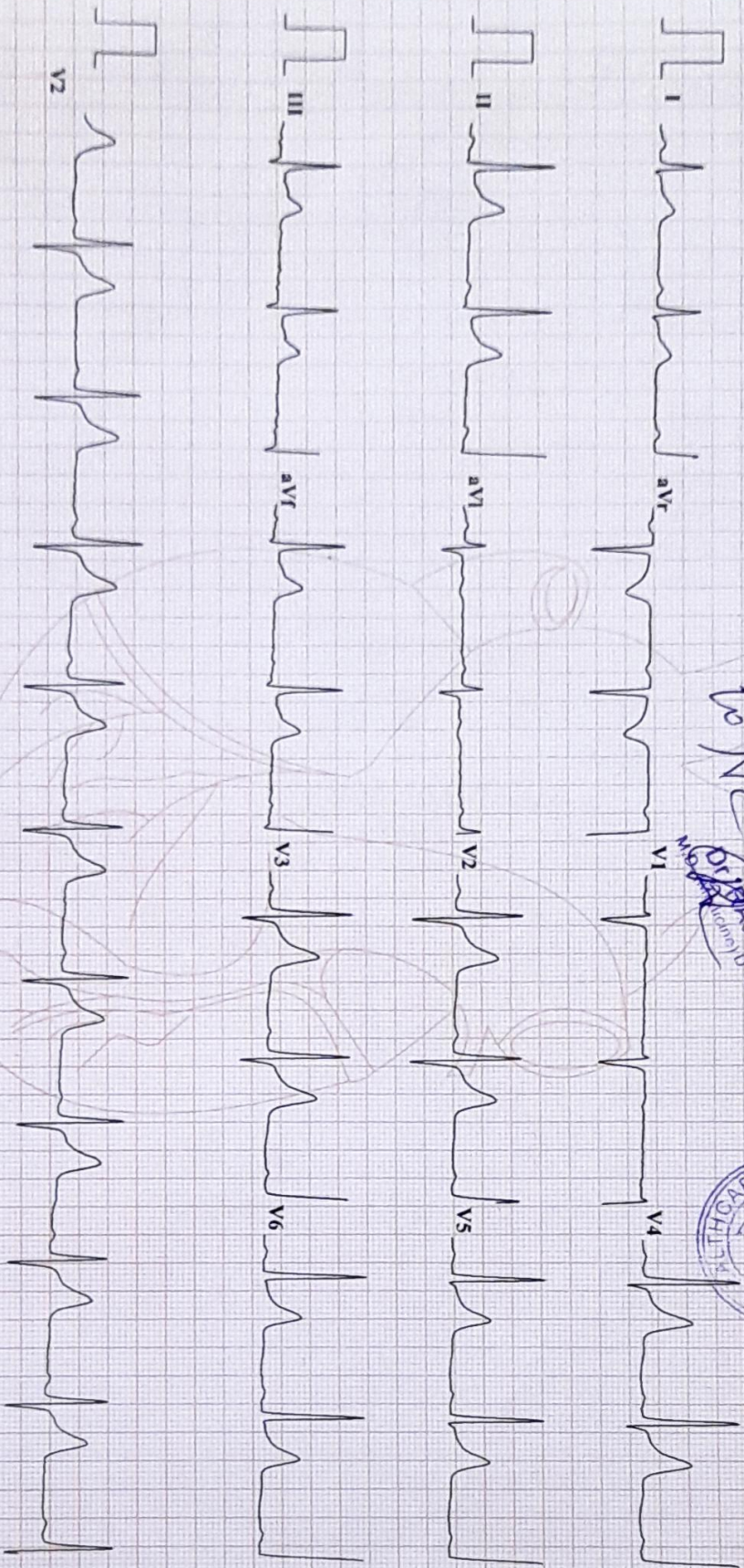
**MR. SUSHILA DEVI**  
 LD : 12  
 AGENCY : S.Y.F.  
 HDW : /  
 DATE : 08-11-2024 11:48:48 AM  
 REF BY : Dr  
 MACHINE INTERPRETATION : Normal ECG.

RATE : 63 bpm  
 BP : N/A  
 P Axis : 27 deg.  
 QRS Axis : 62 deg.  
 T Axis : 66 deg.

P Duration : 109 ms  
 PR Duration : 145 ms  
 QRS Duration : 109 ms  
 QT Interval : 409 ms  
 QTc Interval : 418 ms

**Linked Median**  
 Speed : 25 mm/s  
 Sensitivity : 10 mm/mV

Dr. **ADARSH KUMAR**  
 MD (General Medicine) D. Card. F.I.C.C.



Filtered (35 Cycle) And Base Corrected

UNHEM, Indore, Tel: +91-731-4092003, Fax: +91-731-4031180, E-Mail: [ecg@ektronmedicals.net](mailto:ecg@ektronmedicals.net), Web: [www.unhe.com](http://www.unhe.com), ECG Ver 1.0.1

Dr.



# Shri Durga Health Care

Consultation : Computerized Pathological Lab ECG, CTMT, PFT

Name:	SUSHILA DEVI	Sex:	FEMALE
Lab. No:	202401101	Age:	52
Date:	8/11/2024	Ref. By	LIC

## LIPIDOGRAM

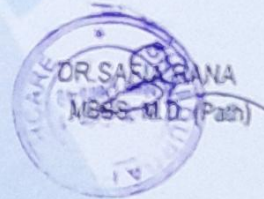
<u>Test Name</u>	<u>Value</u>	<u>Unit</u>	<u>Normal Value</u>
Total Cholesterol	160	mg/dl	120 - 220
High Density Lipid (HDL)	38	mg/dl	35-70
Low Density Lipid (LDL)	95	mg/dl	50 - 150
S. Triglycerides	133	mg/dl	25 - 160

## BIOCHEMISTRY

<u>Test Name</u>	<u>Value</u>	<u>Unit</u>	<u>Normal Value</u>
Blood Sugar Fasting	101	mg/dl	70-140

## HAEMATOLOGY

<u>Test Name</u>	<u>Value</u>	<u>Unit</u>	<u>Normal Value</u>
Hemoglobin (HB)	12.8	mg/dl	13.2 - 16.2 (M) 12.0 - 15.2 (F)



# SDHC

D-63, Ground Floor, South Exn. Part-1, Near Barat Ghar, New Delhi-110049

Mob : 9899994465 | E-mail : healthcareshridurga@gmail.com

Note Valid For Medico-legal Purposes

Home Sample Collection Facility Available | Timing : 8:00 am To 8: Pm (Sunday Open)



# Shri Durga Health Care

Consultation : Computerized Pathological Lab ECG, CTMT, PFT

Name:	SUSHILA DEVI	Sex:	FEMALE
Lab. No:	202401101	Age:	52
Date:	8/11/2024	Ref. By	LIC

## URINE ROUTINE EXAMINATION

### PHYSICAL EXAMINATION

<u>TEST NAME</u>	<u>VALUE</u>	<u>NORMAL VALUE</u>
Color	P.Yellow	P.Yellow
Quantity	15ml	
Appearance	Clear	Clear
Reaction	Acidic	Acidic
Deposits	Nil	Nil
Specific Gravity	1.025	1.010 - 1.030

### CHEMICAL EXAMINATION

Albumin	Nil	Nil
Sugar	Nil	Nil

### MICROSCOPIC EXAMINATION

Pus Cells	2-3	0 -5 /HPF
Epithelial Cells	2-4	0 -5 /HPF
RBCs	Nil	Nil /HPF
Crystals	Nil	Nil
Cast	Nil	Nil
Bacteria	Nil	Nil
Others	Nil	Nil

DR. SAFIA RANA  
MBBS, M.D. (Path)



D-63, Ground Floor, South Exn. Part-1, Near Barat Ghar, New Delhi-110049

Mob : 9899994465 | E-mail : healthcareshridurga@gmail.com

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**durga** HEALTHCARE  
(CHAUDHARY DURGA SINGH)  
HEALTHCARE PRIVATE LIMITED


DR. HARINDER

DR. SIDDHARTH

DR. POOJA



*Dr. Preeti Himan*  
M.R.B.S.

 **GPS Map Camera**



**New Delhi, Delhi, India**

D-63, near Bank of Baroda, South Extension I, Block D, New Delhi, Delhi 110003, India

Lat 28.572248°

Long 77.221445°

08/11/24 11:34 AM GMT +05:30

 Google