



GYNECOLOGICAL CHECK UP

S/B Dr. : Suati Bhimani Date: 12/03/25

Name : Mrs. Champaben Purnau Age / Sex : 50/F

COMPLAINTS : NO COMPLAINTS
Abdominal pain / Leucorrhoea/ Dysmenorrhoea / Menorrhoea/
Polymenorrhoea / Discharge PV / Itching PV / Mass PV /
Post Coital Bleed / Dysparunja

MENSTRUAL HISTORY : _____
MENSTRUAL CYCLE : Reg /
DAYS / Irreg.,
FLOW : Mod / Heavy _____

LMP : 5 Month back.

OBS HISTORY : _____
Duration of Married Life

NO. OF CHILDREN : _____
G P L A 2FTMS.

NO.	AGE	SEX	MODE OF DELIVERY	OTHERS

DESIRES CONTRACEPTION : YES / NO
MODE OF CONTRACEPTION : Safe Period / Barrier / IDU / OCP / Others

D / E : P / A : Soft

P / S : 1. Pt doesn't want

P / V : _____

BREAST NAD : Rt : _____ Lt : ACH

ADVICE : _____
Mammography



CONSULTANT'S SIGNATURE : _____

Mrs. Chumpa Parmar

Age:- 50 / F

Old: Stain. Calculus ++

- Missing $\frac{6}{6}$
- Carious $\frac{8}{8}$
- Root piece $\frac{8}{8}$

Adv: TO PA $\frac{8}{8}$

- Deep Scaling.
- Rest^m $\frac{8}{8}$
- Replacement of missing teeth $\frac{6}{6}$
- Ext^m $\frac{8}{8}$



[Handwritten signature]



EYE CHECK UP

Reg. No. : # Date : 12-3-2025

Name : MRS. Chhampaben Parmar Age / Sex : 50/F

	RIGHT EYE	LEFT EYE
DISTANCE : (With / Without Glasses)	6/6	6/6
NEAR VISION : (With / Without Glasses)	N6	N6
ANTERIOR SEGMENT :	— WNL —	
I O P (MM of Hg)	— digitally wnl —	
FUNDUS :	— WNL —	
COLOR VISION :	— WNL —	
CLINICAL IMPRESSION :	— WNL —	
ADVICE :	— Glass use —	

Doctor's Signature : P. Shah





COMPREHENSIVE HEALTH CHECK UP

Case No. : # Date : 12-3-25

Name : Mrs Chumpaben Parmar Age/Sex : 50/F

MEDICAL HISTORY : Hypothyroidism - Recently detected

PERSONAL HISTORY : _____

Appetite : _____ Smoking : _____

Sleep : _____ H/O Alcohol : _____

Bladder : _____ Lifestyle : _____

Bowel : _____ Exercise : _____

DRUG HISTORY : _____

PAST HISTORY : _____

FAMILY HISTORY : _____

GENERAL PHYSICAL EXAMINATION :

Built and Nourishment :

Height : 152 cm

96.1

B. P. : 110/80 mm of Hg

Weight : 53.2 Kg

Character : —

Pulse : 75 / Min

Nails : —

Odema : —

Tonsils : —

Skin : —

Tongue : —

Sclera : —

Eat. & Joints : —

Glands : Ad



(30) Ad - Tb. Thyronorm 1000
1000

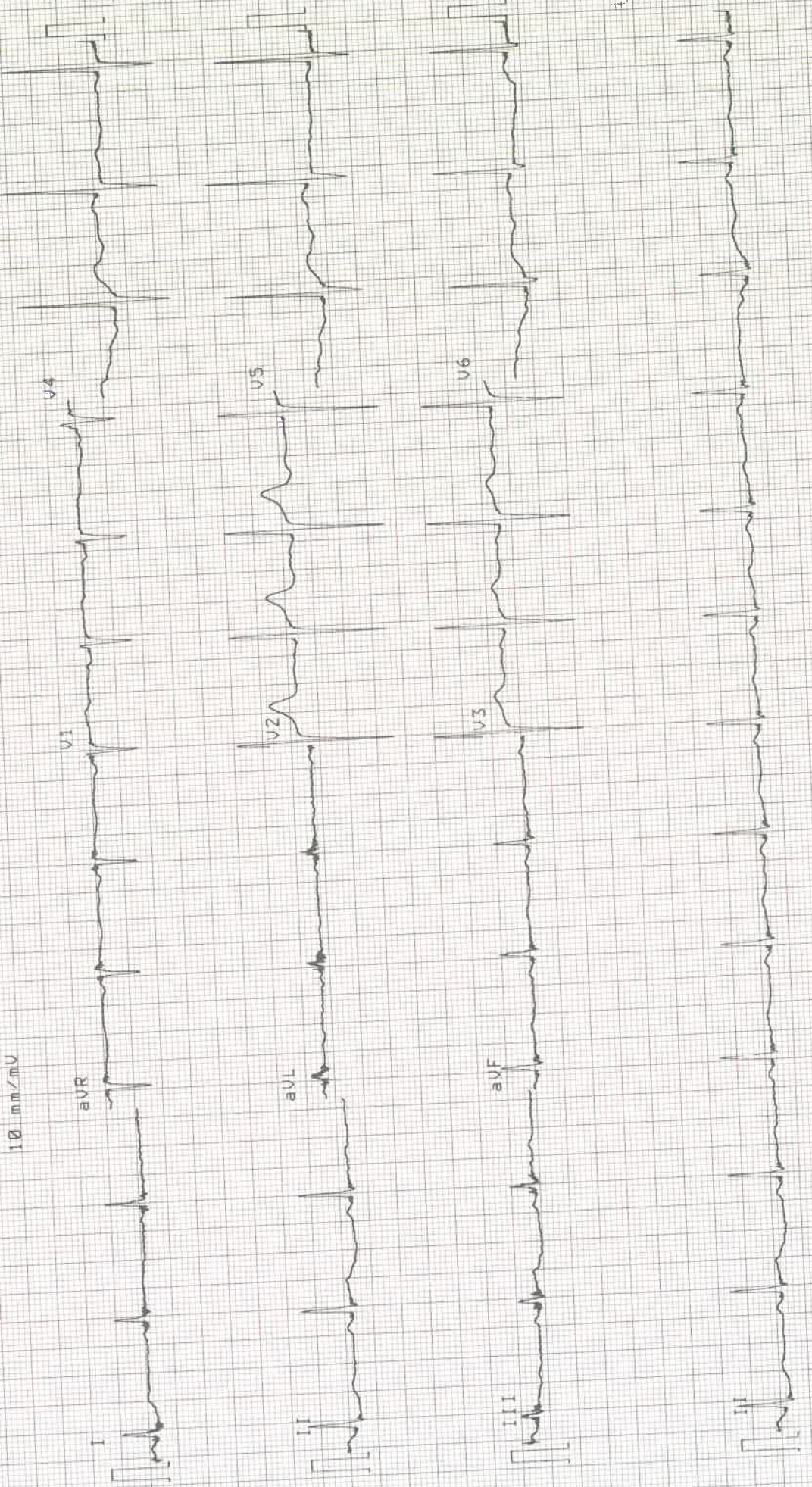
SINUS RHYTHM
NORMAL ECG

UNCONFIRMED REPORT



DR. PAVAN ROY
MD, DM (CARDIOLOGY)
CONSULTANT CARDIOLOGIST
REG. NO. G-23390
M No. 9305988166

10 mm/mV



10 mm/mV

HR 76/min
Axis: 42°
P 42°
QRS 39°
T 65°

Intervals:
RR 794 ms
P 104 ms
PR 142 ms
QRS 84 ms
QT 382 ms
QTc 429 ms

P (II) 0.09 mV
S (V1) -0.76 mV
R (V5) 1.67 mV
Sokol. 3.25 mV

parmar
champaben
.....
50 years
..... cm / kg
Female

10 mm/mV

Patient Name : MRS. CHAMPABEN R PARMAR
Age & Sex. : 50Y /F
Bill date : 12/03/2025 11:40 AM

Bill No. : OPB/1/24/17527
Reg No. : REG-17058
Sponsor : MEDIWHEEL

X-RAY CHEST PA

Both the lung fields appear normal.

Both costophrenic angles appear clear.

Cardiac silhouette appear normal.

Both hila appears normal.

Bony thorax appears normal.

No evidence of free gas seen under dome of diaphragm.

COMMENTS:

- **NORMAL BOTH LUNG FIELDS.**
- **NORMAL CARDIAC SIZE.**

Impression :
Conclusion :



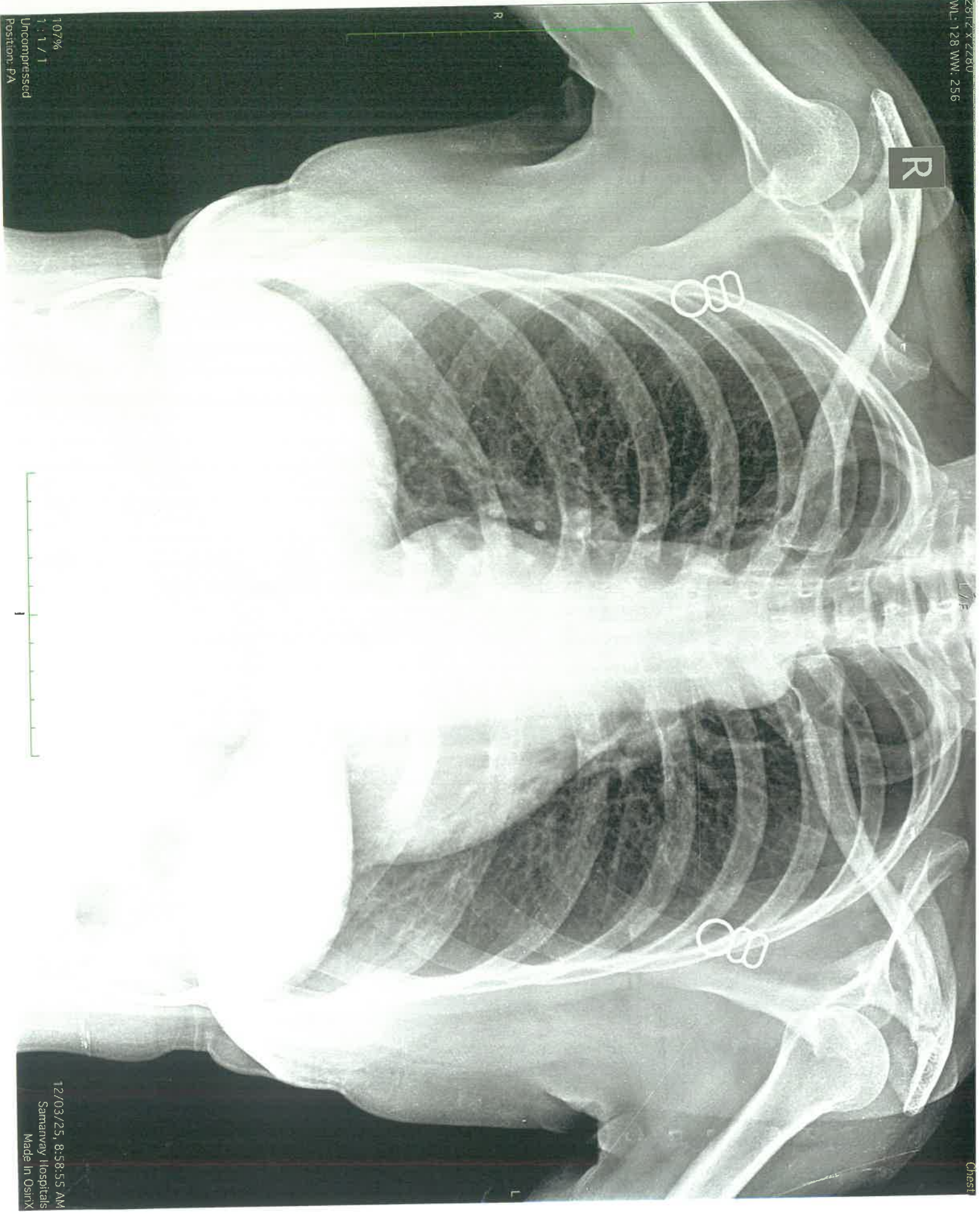
Dr. Sarjan Vasava

Radiology
(Reg No-G-26527)



DR SARJAN VASAVA
M.B.B.S. D.M.R.D.
Reg. No. G-26527
SAMANVAY HOSPITALS

Chumpasen Poomus 504/F



2812 X 2280
WL: 128 WW: 256

107%
1:1/1
Uncompressed
Position: PA

Chest

12/03/25, 8:58:55 AM
Samnang Hospital
Made In Ostrich

CHAMPABEN PARMAR

50 YEARS/FEMALE

12/03/2025

REAL TIME SONOGRAPHY OF THE ABDOMEN & PELVIS

LIVER - It is normal in size (14.8 cm). It shows normal echo pattern. No evidence of solid or cystic focal lesion is seen. The intrahepatic biliary system is normal and shows no dilatation of the radicles. The portal vein, CBD and hepatic veins appear normal.

GALL BLADDER - It is distended and appears normal. No evidence of sludge or calculus is seen. The wall appears normal.

PANCREAS - It is visualized and appears normal.

SPLEEN - It appears normal in size (8.2 cm), normal in shape and echotexture. No focal lesions.

KIDNEYS - Both the kidneys appear enlarged in size, and show multiple cysts of variable size and loss of corticomedullary differentiation. Increased echogenicity of both kidneys.

Right kidney measures 13.9 x 7.3 cm. Left kidney measures 12.9 x 7.3 cm.

No calculus or hydronephrosis is seen on either side.

Urinary bladder is distended and appears normal. No cystitis or mass lesion noted.

Uterus appears normal. ET measures 8.7 mm. No focal lesion.

Both adnexa appears normal.

No evidence of any lymphadenopathy or ascites is noted.

No evidence of dilated bowel loops or bowel wall thickening noted.

IMPRESSION:

BILATERAL MULTICYSTIC KIDNEYS.

DR SARJAN VASAVA
M.B.B.S., D.M.R.D.
Reg. No. G-26527
SAMANVAY HOSPITALS

DR. SARJAN VASAVA,
CONSULTANT RADIOLOGIST.



Patient

Exam

ID 12032025-091307AM
 Name CHAMPABEN PARMAR F/50
 Birth Date
 Gender

Accession #
 Exam Date 12-03-2025
 Description
 Operator



2D ECHOCARDIOGRAPHY AND COLOUR DOPPLER STUDY

NAME : MRS CHAMPABEN PARMAR

DATE : 12-03-25

AGE/SEX : 50YRS / F WARD :HCP REF BY :SAMANVAY HOSPITAL

OBSERVATION:

- NORMAL LV SIZE WITH NORMAL LV SYSTOLIC FUNCTION
- LVEF 56%, NO RWMA AT REST
- MILD CONCENTRIC LVH
- E/O GRADE I LV DIASTOLIC DYSFUNCTION
- AORTIC VALVE- TRIVIAL AR, NO AS
- MITRAL VALVE- MILD MR, NO MS
- MILD TR, MILD PAH, RVSP ~ 38 mmHg
- PULMONARY VALVE- NO PR, NO PS, NORMAL SIZED PA & ITS BRANCHES
- NORMAL SIZED RA, RV WITH NORMAL RV FUNCTION
- IAS, IVS ARE INTACT
- NO INTRACARDIAC CLOT, VEGETATION
- PERICARDIUM NORMAL, NO PERICARDIAL EFFUSION
- IVC NORMAL

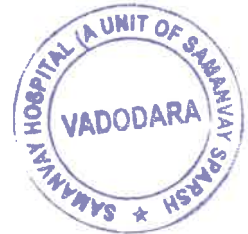
MEASUREMENTS:

M MODE: AORTA: 20 MM LA: 33 MM LV DD/DS: 42/26 MM IVS/PW: 12/12 MM
DOPPLER: MV RATIO E/A: 0.5/0.7 M/S AV VMAX: 1.1 M/S PV VMAX: 0.7 M/S

CONCLUSION:

**NORMAL LV SIZE WITH NORMAL LV SYSTOLIC FUNCTION
LVEF 56%, NO RWMA AT REST
MILD CONCENTRIC LVH
MILD MR, MILD TR, MILD PAH
E/O GRADE I LV DIASTOLIC DYSFUNCTION**

DR. PAVAN ROY
MD, DM (CARDIOLOGY), REG NO. G-23390
CONSULTANT INTERVENTIONAL CARDIOLOGIST



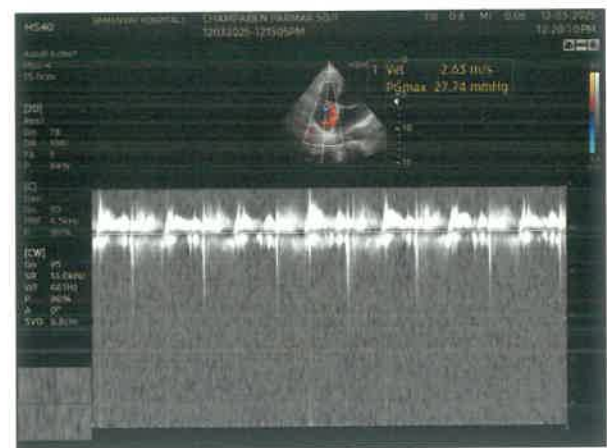
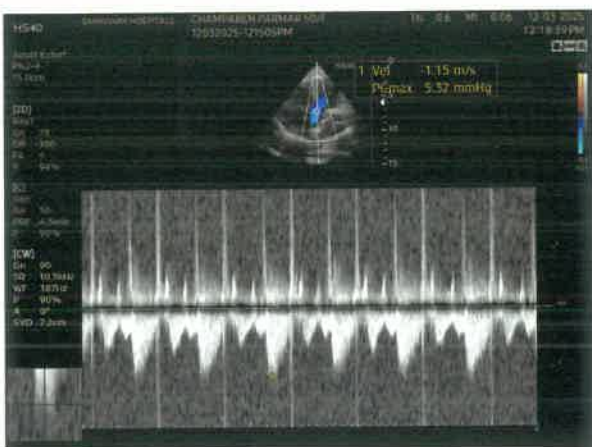
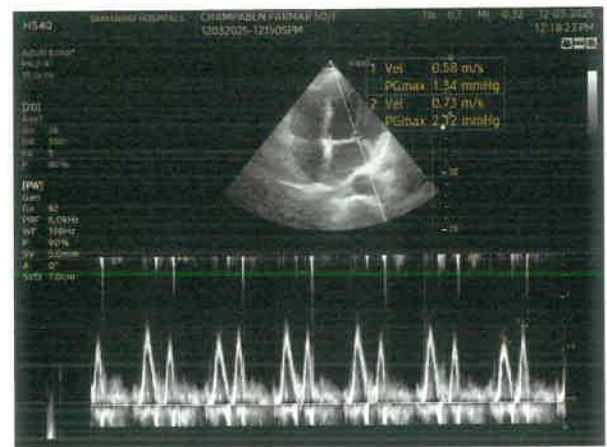
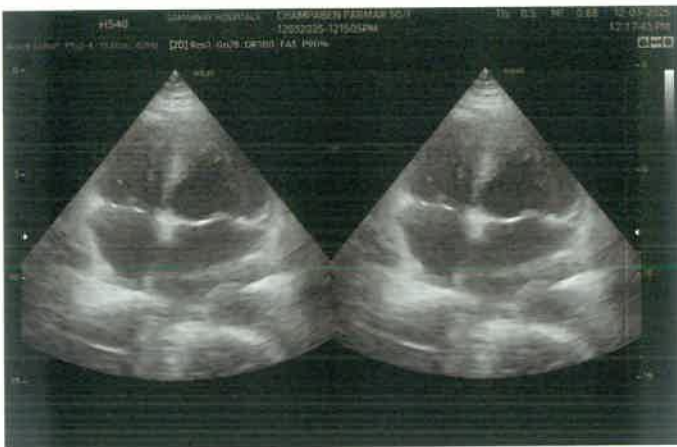
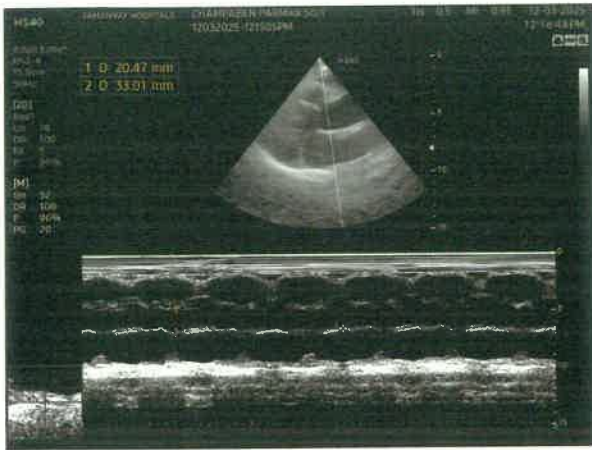
DR. PAVAN ROY
MD, DM (CARDIOLOGY)
CONSULTANT CARDIOLOGIST
REG. NO. G-23390
M No. 9305988158

Patient

ID 12032025-121505PM
 Name CHAMPABEN PARMAR 50/F
 Birth Date
 Gender

Exam

Accession #
 Exam Date 12-03-2025
 Description
 Operator



PHARMACY DIAGNOSTIC & RESEARCH CENTRE

CHAMPANEL PHARMACY 20A, 150352, F. MAMMOGRAPHY 15-03-2008 11-10

WCC

WCC

WCC

WCC

PARAMOUNT DIAGNOSTIC & RESEARCH CENTRE

(A Unit of Paramount Charity Trust)

Radiology ■ Pathology ■ Histopathology ■ Molecular Biology

NAME : CHAMPABEN PARMAR

AGE : 50 Y/F

DATE : 12/03/2025

MAMMOGRAPHY OF BOTH BREAST

Mammography of the both breasts was done by obtaining the CC and MLO views.

OBSERVATIONS:

There are moderate amount of heterogeneously scattered fibro glandular breast parenchyma.-Dense breast.

No evidence of any mammographic mass or architectural distortion.

No evidence of any obvious abnormal ductal dilatation.

No evidence of any microcalcifications.

No evidence of any nipple retraction or skin thickening.

Nipple and areolar region appears normal.

Both axillary region is normal.

COMMENTS:

Dense both breast- Type - D

BIRADS: Category O.

Needs additional imaging evaluation and or Comparison to Prior Mammograms is Needed.

shaily
DR. SHAILY JANI (M.D. , DNB)
CONSULTANT RADIOLOGIST

Dense parenchyma of breast limits the sensitivity of examination.

False negative rate of mammography is about 10%.

Management of clinically palpable lump would be further help.

Women with no symptoms

Age: 35-39: Baseline study, Age: 40-49: every 1-2 years, Age: 50 and above: Every year.




24 hours Emergency Service Available for CT Scan / MRI / Pathology AMBULANCE SERVICE AVAILABLE

Main Branch : Paramount Complex, Gotri Road, Race Course, Vadodara. Ph.: 0265 - 2395772, 2397438, +91 - 6352731483,

Path. Lab : 0265 - 6603900/901/902/903, +91 - 8160225911, +91 - 9099066029

City Branch : Opp. Brahman Sabha Hall, Pratap Road, Dandiabazar, Vadodara. Ph.: 0265 - 2423233, +91 - 6352734810

Patient Name : MRS. CHAMPABEN R PARMAR
Age / Sex : 50Y/Female
IP/Reg.No/UHID : Reg-17058 /UHID17058
Lab No : LA25003113
Referred By : Dr.SAMANVAY HOSPITAL
Bedcategory/Bed :
Mobile No : 8320032476
UHID : UHID17058
Consultant : Mr. Samanvay Hospital
Sponsor : **MEDIWHEEL**
Barcode No. : 48135,48136,48137

Bill No : OPB/1/24/17527
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Verified On : **Mar 12 2025 12:54PM**

Test Name

Results

Units

Bio. Ref. Interval

BIOCHEMISTRY

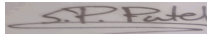
LIVER FUNCTION TEST

BILIRUBIN-TOTAL	0.53	mg/dl	0.00 - 2.0
Method :- DIAZO			
BILIRUBIN-DIRECT	0.20	mg/dl	0.00 - 0.4
Method :- DIAZO			
BILIRUBIN-INDIRECT	0.33	mg/dl	0.00 - 1.10
Method :- DIAZO			
SGOT	12.6	U/L	0 - 31
Method :- IFCC WITHOUT PYRIDOXAL PHOSPHATE			
SGPT	11.6	U/mL	0 - 34
Method :- IFCC WITHOUT PYRIDOXAL PHOSPHATE			
ALKALINE PHOSPHATASE(ALKP04)*	124.0	U/L	42 - 141
Method :- AMP-METHOD			
PROTEIN (SERUM)	6.40	g/dl	6.40 - 8.30
Method :- BIURET			
ALBUMIN	3.84	g/dl	3.5 - 5.2
Method :- BCG			
GLOBULIN	2.56	g/dl	2.3 - 3.7
Method :- CALCULATED			
A/G RATIO	1.50	Ratio	1.0 - 2.0
Method :- CALCULATED			
UREA	30.4	mg/dl	21.0 - 43.0
Method :- UREASE-GLDH			
URIC ACID	3.7	mg/dl	2.6 - 6.0
CREATININE (BLOOD)	↑ 1.62	mg/dl	0.6 - 1.1
Method :- ENZYMATIC			
BUN	14.20	mg/dl	5.0 - 21.0
Method :- UREASE-GLDH			

LIPID PROFILE

Mrs. Rachana Parsottambhai Dayma

Prepared by




Dr. Sweta Patel
MD (Pathology)

Verified By

Nr. St. Kabir School, Opp. Raneshwar Temple, Vasna Road, Vadodara-15

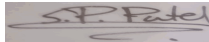
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Test Name	Results	Units	Bio. Ref. Interval
CHOLESTROL (TOTAL) Method :- CHOD-PAP	177.0	mg/dl	0.0 - 200.0 Desirable blood cholesterol : <200 mg/dl Borderline high blood cholesterol : 200-239 mg/dl High blood cholesterol : >239 mg/dl
TRIGLYCERIDE Method :- GPO-METHOD	103.3	mg/dl	0 - 161.0 NORMAL : <161 MG/DL HIGH : 161-199 MG/DL HYPERTRIGLYCERIDEMIC : 200-499 MG/DL
HDL CHOLESTEROL Method :- DIRECT METHOD	↓ 38.9	mg/dl	42.0 - 88.0
CHOLESTROL (TOTAL)/HDL RATIO Method :- CALCULATED	↑ 4.55		3.30 - 4.40
VLDL	20.66		0 - 30.0
LDL CHOLESTEROL(CALCULATED)	↑ 138.1		0 - 130.0
LDL/HDL RATIO	3.55		
GAMMA GT Method :- GLUPA C METHOD	11.8	U/L	0.0 - 58.0
FASTING BLOOD GLUCOSE* FASTING BLOOD GLUCOSE(FBS) Method :- GOD-POD	90.6	mg/dl	74.0 - 100.0
FASTING URINE GLUCOSE	NIL		
IMMUNOLOGY			
T3 T4 TSH TOTAL T3 Method :- CHEMILUMINESCENCE / CLIA	0.76	ng/ml	0.6 - 1.8
TOTAL T4 Method :- CHEMILUMINESCENCE / CLIA	↓ 4.20	ug/dl	4.5 - 12.7

Mrs. Rachana Parsottambhai Dayma


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Dr. Sweta Patel
MD (Pathology)
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Test Name	Results	Units	Bio. Ref. Interval
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TSH	↑ 25.04	μIU/mL	0.35 - 4.78
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Method :- CHEMILUMINESCENCE / CLIA

Interpretation :
1. TSH results between 4.5 to 15.0 show considerable physiologic and seasonal variation, suggest clinical correlation or repeat testing with fresh sample.
2.TSH results between 0.1 to 0.45 requires correlation with patient age and clinical symptoms. As with increasing age, there are marked changes in thyroid hormone production, metabolism and its action resulting in an increase prevalence of sub-clinical thyroid disease.
3. TSH values may be transiently altered because of non- thyroidal illness like severe infections, liver diseases, renal and heart failure, severe burns, trauma and surgery etc.
4. Drugs that decreased TSH values e.g. L-dopa, glucocorticoid. Drugs that increase TSH values e.g .Iodine, Lithium and amiodarone.

HPLC

HBA1C/ GLYCO HB

GLYCOCYLATED HAEMOGLOBIN(HBA1C)	4.7	%	4.0 - 6.0
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Method :- HPLC

AVERAGE BLOOD SUGAR	88.19	mg/dl	0 - 140.0
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BIOCHEMISTRY

POST BLOOD GLUCOSE(PP2)

PP2 BLOOD GLUCOSE	98.2	mg/dl	70.0 - 140.0
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Method :- GOD-POD

PP2 URINE GLUCOSE

NIL

HEMATOLOGY

CBC WITH ESR

RBCS PARAMETER

HAEMOGLOBIN	↓ 11.3	g/dl	13.0 - 17.0
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Method :- SLS METHOD

RBC COUNT	↓ 4.05	10 ⁶ /uL	4.50 - 5.50
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Method :- IMPEDENCE

PCV (HEAMATOCRIT)	↓ 37.6	%	40.0 - 50.0
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Method :- IMPEDENCE

MCV	92.8	fl	80.0 - 100.0
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Method :- CALCULATED




Mrs. Rachana Parsottambhai Dayma

Dr. Sweta Patel
MD (Pathology)

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Verified By

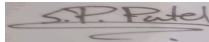
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MCH	27.9	pg	27.0 - 33.0
Method :- CALCULATED			
MCHC	↓ 30.1	g/dl	32.0 - 36.0
Method :- CALCULATED			
RDW-CV	13.8	%	11.6 - 14.0
Method :- PARTICLE COUNTER(CALCULATED)			
RDW-SD	↑ 46.8	fl	39 - 46
Method :- PARTICLE COUNTER(CALCULATED)			
WBCS PARAMETER			
TOTAL COUNT	6090	/uL	4000 - 10000
Method :- FLOW CYTOMETRY			
DLC			
NEUTROPHILS	64	%	40 - 70
Method :- FLOW CYTOMETRY			
LYMPHOCYTES	28	%	20 - 40
Method :- FLOW CYTOMETRY			
MONOCYTES	04	%	2 - 8
Method :- FLOW CYTOMETRY			
EOSINOPHILS	04	%	1 - 4
Method :- FLOW CYTOMETRY			
BASOPHILS	00	%	0.0 - 1.0
Method :- FLOW CYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT	3860.0	10 ³ /uL	2000.0 - 7000.0
Method :- CALCULATED			
ABSOLUTE LYMPHOCYTE COUNT	1700.0	10 ³ /uL	1000.0 - 3000.0
Method :- CALCULATED			
ABSOLUTE MONOCYTE COUNT	240.0	10 ³ /uL	200.0 - 1000.0
Method :- CALCULATED			
ABSOLUTE EOSINOPHIL COUNT	230.0	10 ³ /uL	20.0 - 500.0
Method :- CALCULATED			
PLATELETS PARAMETER			

Mrs. Rachana Parsottambhai Dayma


Prepared by



Dr. Sweta Patel
MD (Pathology)

Verified By

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Test Name	Results	Units	Bio. Ref. Interval
PLATELET COUNT	195000	/uL	150000 - 450000
Method :- IMPEDENCE MPV	10.7	fl	8.0 - 13.0
Method :- IMPEDENCE PDW	12.9	fl	9.0 - 17.0
Method :- IMPEDENCE ESR	08	mm/hr	0 - 20
BLOOD GROUP RH	"B" POSITIVE		

-----End of the Report-----

Mrs. Rachana Parsottambhai Dayma

Prepared by



Dr. Sweta Patel

MD (Pathology)

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Nr. St. Kabir School, Opp. Raneshwar Temple, Vasna Road, Vadodara-15