

Patient Name : Sunilkumar Gandabhai Parmar	Sample No. : 24000632
Patient ID : CH-2024-0059137	Visit No. : OPD/2024/11/0000288
Age / Sex : 39y / Male	Coll. Date : 11/11/2024 09:08
Visit Doctor : DR. NAITIK BHATIA	S. Coll. Date : 11/11/2024 09:37
Ward : -	Report Date : 11/11/2024 12:03

HEMATOLOGY

Hemoglobin (HB)

Investigation	Result	Normal Value
Hemoglobin	13.40 gm/dl	14.0 - 18.0 mg/dl

WBC

Investigation	Result	Normal Value
WBC Count	4570 /c.mm	4000.0 to 10000.0 /c.mm

WBC count - Differential

Investigation	Result	Normal Value
Polymorphs	55.00 %	40.0 - 70.0 %
Lymphocytes	42.00 %	20.0 - 40.0 %
Eosinophils	1.00 %	1.0 - 6.0 %
Monocytes	2.00 %	2.0 - 10.0 %
Total	100.00	

Platelet count

Investigation	Result	Normal Value
Platelets Count	215000 /cmm	1,50,000 - 4,50,000 /cmm

Blood Group

TEST	RESULT
Blood Group	B
Rh Factor	Positive

ESR

Investigation	Result	Normal Value
ESR After One Hour	8 mm	3.0 - 5.0 mm

DR. NAITIK BHATIA
CONSULTANT PATHOLOGIST
(M.B.B.S.,D.C.P)


DR. KETAN KAPADIA
CONSULTANT PATHOLOGIST
(M.B.B.S.,M.D)

Patient Name : Sunilkumar Gandabhal Parmar	Sample No. : 24000632
Patient ID : CH-2024-0059137	Visit No. : OPD/2024/11/0000268
Age / Sex : 39y / Male	Coll. Date : 11/11/2024 09:08
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Card :-	Report Date : 11/11/2024 12:03

BIOCHEMISTRY

FASTING BLOOD GLUCOSE

Investigation	Result	Normal Value
Fasting Blood Sugar	100.22 mg/dL	70 to 110 mg/dL

BLOOD UREA

Investigation	Result	Normal Value
Blood Urea	21.31 mg/dl	15 - 40 mg/dl

CREATININE

Investigation	Result	Normal Value
Creatinine	1.01 mg/dl	M : 0.7 to 1.5

URIC ACID

Investigation	Result	Normal Value
Uric Acid	5.13 mg/dl	2.5 to 7.0 mg/dl

UREA

Investigation	Result	Normal Value
UREA	9.96 mg/dl	8.0 - 23.0 mg/dl

IMMUNOLOGY

THYROID

Investigation	Result	Normal Value
THYROID	4.28 uIU/ml	0.34 - 4.5 uIU/ml

THYROID FUNCTION TESTS

Investigation	Result	Unit	Reference Range
Free T3	1.62	ng/ml	0.69 - 2.15 ng/ml

Investigation	Result	Normal Value
Free T4	70.4 ng/dl	52.0 - 127.0 ng/dl

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BIOCHEMISTRY

LIVER FUNCTION TEST

Investigation	Result	Normal Value
PT	21.89 IU/L	0 to 40 IU/L
APOT	21.86 U/L	0.0 to 45.0 U/L
Total Bilirubin	0.43 mg/dl	0.2 - 1.3 mg/dl
Direct Bilirubin	0.12 mg/dl	0.0 to 0.3 mg/dl
Indirect Bilirubin	0.31 mg/dl	0.2-0.90 mg/dl
Alkaline Phosphatase	70.51 IU/L	15 - 100 years 37.0 - 147.0 IU/L
Albumin	7.3 gm/dl	5.0 - 10.0 gm/dl
Urea Nitrogen	3.91 gm/dl	3.5 to 5.0 gm/dl
Creatinine	3.39 gm/dl	2.4 to 3.5 mg/dl
Hemoglobin	1.15	1.1 to 2.5

LIPID PROFILE

Investigation	Result	Normal Value
Total Cholesterol (Chol)	196.38 mg/dl	Low risk : < 200 Moderate risk : 200 - 239 High risk : > or = 240
Triglyceride	152.82 mg/dl [H]	Normal : < 150.0 Borderline high : 150 - 199 High : 200 - 499 Very High : > or = 500
LDL Cholesterol	43 mg/dl	Negative risk : > or = 60 High risk : < 40
HDL Cholesterol	122.82 mg/dL	
LDL/HDL Ratio	30.56 mg/dl	Up to 0 to 34 mg/dl
Total/HDL Ratio	2.86	0.5 to 3.0(Low) 3.0 to 6.0(Moderate) > 6.0(High)
Total Cholesterol / HDL Ratio	4.57	Low Risk : 3.3 to 4.4 Average Risk : 4.4 to 7.1 Moderate Risk : 7.1 to 11.0 High Risk : > 11.0
Total Lipids	599.23 mg/dl	400 to 700 mg/dl

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Sex : 39y / Male	Coll. Date : 11/11/2024 09:08
Doctor : DR. NAITIK BHATIA	S. Coll. Date : 11/11/2024 10:40
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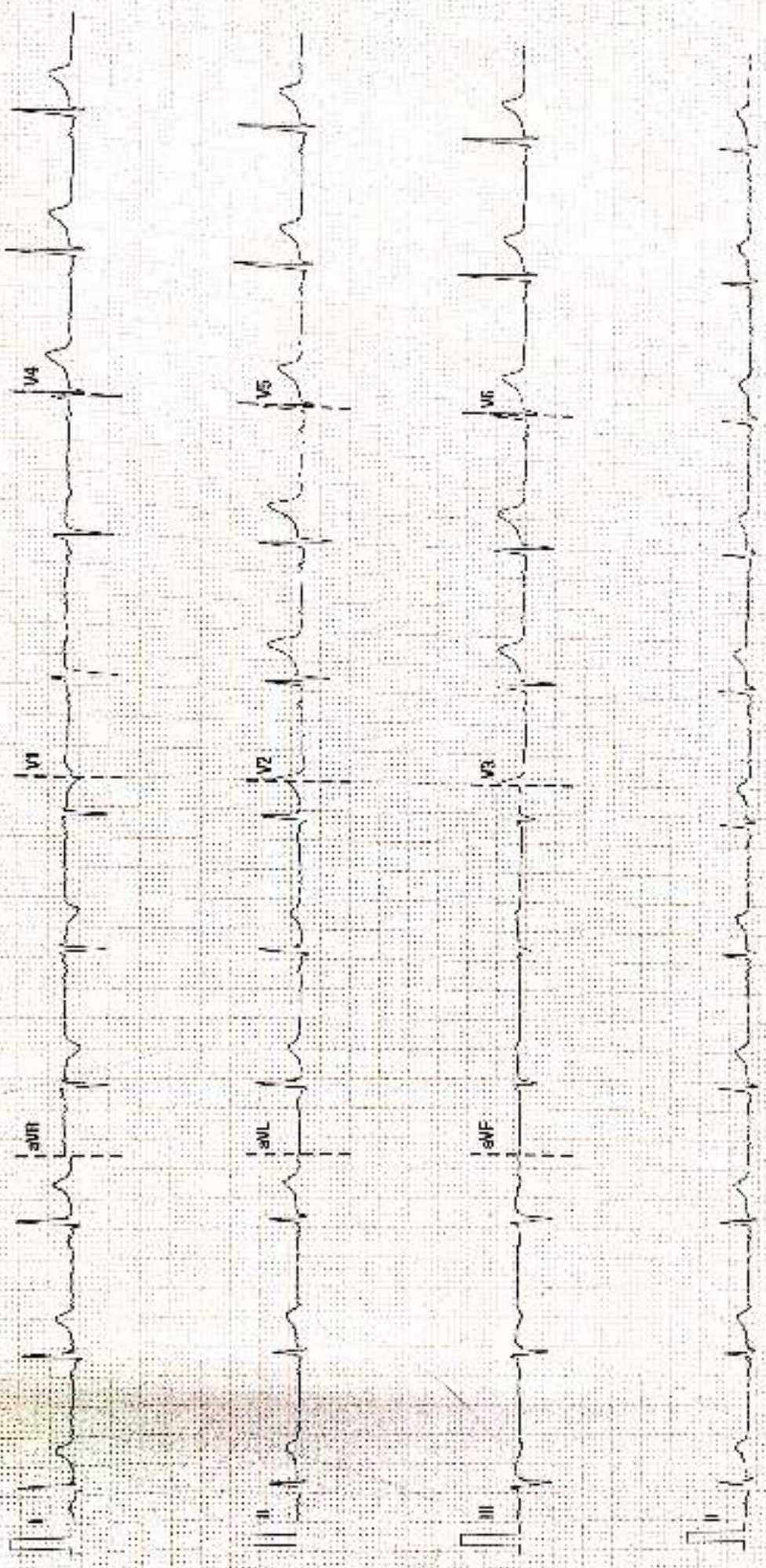
CLINICAL PATHOLOGY

HE R & M

HE R & M	RESULT
Physical Examination :	
Color	30
Consistency	Pale Yellow
Clarity	Clear
Appearance	URINIOD
pH	Acidic
Density	1.030
Specific Gravity	
Microscopic Examination :	
Microbes	Absent
Crystals	Absent
Salts	Absent
Pigments	Absent
Blood	Absent
Urobilinogen	Absent
Microscopic Examination :	
Cells	1-2
Bacteria	Absent
Epithelial cells	1-2

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LALITABEN P. D. PATEL OPD SERVICES

REGISTRATION FORM (OPD)



Dr. AIPesh

Date & Time : 11/11/24

Registration No. : CH-24-0059137

Name : Sunilkumar G. Parmar

Contact No. : (M) _____

Age : 39 Sex : M

(O) _____

Address : _____

B.P. : 100/60

Pulse : _____

SpO₂ : _____

MI : _____

Height : _____

Weight : _____

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : _____

CASE ANALYSIS

Past History : _____

Present History : _____

PE Vitals : _____

Systemic Examination : _____

FAMILY HISTORY :

- Diabetes
- IHD
- Hypertension
- Others (Specify) : _____

PATIENT'S MEDICAL/OTHER HISTORY :

- Hypertension
- IHD
- T.B.
- Jaundice
- Epilepsy
- Asthma
- Hepatitis B
- Hepatitis C
- Food Allergy
- AIDS/HIV
- Bleeding Disorder
- Drug Allergy
- Pregnancy
- Others (Specify) : _____

ADDICTS : Smoking

Alcohol

Tobacco

Others (Specify) : _____

Investigation/s Advised : _____

Provisional Diagnosis : _____

Allergy : _____

Nutritional Advice : _____

TREATMENT ADVISED		REMAI
DATE	DOCTOR'S NOTE	
<u>11/11/2024</u>	<u>SIB Q. A/P esh</u> Δ :- Hypothyroidism <u>Adm</u> - T-Rosuvastatin (75) 0-07 L (3) months - T-Thyroxine (75) 10-0 L (3) months	
<u>11/11/24</u> <u>Sto 20T</u>	No fish eat clo. Rem. (2) Bron intact	<u>Adm</u>

Date / N/A :-
oe

Signature with Stamp

Neem : No W / No Soaking



Date & Time : 11/11/24
 Registration No. : CH-24-0059137

Name : Sunil Kumar G. Parmar Contact No. : _____
 Age : 39 Emergency Contact No. : _____
 Sex : m Address : _____

OPD-INITIAL ASSESSMENT FORM

Chief Complain : Routine Check up.

Family History :

Diabetes
 Hypertension
 IHD
 Others (Specify) :
 Habits : Tobacco

Hypertension
 Diabetes
 Epilepsy
 Bleeding Disorder
 Smoking

Medical/Other History :

IHD
 Asthma
 AIDS/HIV
 Pregnancy
 Other (Specify) :

Jaundice
 Hepatitis B
 Drug Allergy

સંમતિ પત્રક

..... ડૉક્ટરને મારી સારવાર માટે સંમતિ આપું છું. આ સારવારનો પૂરેપૂરો ખર્ચો, ડાયાગ્નોસ્ટિક-ગેરડાયાગ્નોસ્ટિક, દવાની કે ઈન્જેક્શનની આદ્ય અસર અને સારવારની સફળતા, અસફળતા વિશે મને તથા મારા સંબંધીઓને સમજૂતી આપેલ છે. મેં ડૉક્ટરને મારી શારીરિક સ્થિતિ તથા તેને લગતી દવા વિશે સંપૂર્ણ માહિતી પેલ છે. જો કોઈપણ સંજોગોમાં સારવાર અધૂરી છોડીશ કે અનિયમિત રહીશ તો તેની નિષ્ફળતા માટે ડૉક્ટર કે ચારુસેટ હોસ્પિટલ જવાબદાર નથી. તથા સારવારની ડિપોઝીટ પેટે અપાયેલ રકમ મેળવવા માટે હક્કદાર રહીશ નહીં. આ સંમતિ હું સ્વેચ્છાએ કોઈપણ દબાણ વિના આપું છું.

શ્રીમ : _____
 સ્ત્રી : _____

 દર્દી / સગાની સહી

CONSENT

..... hereby request and authorize Doctor perform the required dental treatment. Doctor has informed me and my relatives about the treatment plan in details with success and failure of the treatment with all expenditure, possible complications from medicines or local anesthesia. I have informed the Doctor about my medical history and drug history in details. If in any circumstances, I am irregular or leave the treatment in between, the doctor and CHARUSAT Hospital will not be responsible for the same and treatment charges will not be returned back.

I give my consent to proceed with my dental treatment.
 Date : _____
 Name : _____

 Patient's / Relative's Sign.

Investigation Advised : _____

Final Diagnosis : _____

Treatment Plan : Routine Check up

Date : _____
 Time : _____
 Name of Doctor : Falg
 Signature : _____

DENTAL DEPARTMENT

Follow up

DATE	DOCTOR'S NAME	ESTIMATE	AMOUNT PAID	AMOUNT
11-11-24	Sealing done (U/L)	600/-	600/-	
			0074653	11/
			11-11-24	



DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
12-11-2024	SUNILKUMAR G PARMAR	M	BODY PROFILE	UM-TOTAL ABDOMEN USG

USG ABDOMEN report.

Liver: show evidence of normal size, parenchymal echotexture & no evidence of focal solid or cystic mass lesion seen. Normal hepatic vasculature seen with no evidence of intrahepatic biliary dilatation seen.

Gall bladder: is contracted with no evidence of calculus or sludge. Thickness of gall bladder wall is normal with no evidence of pericholecystic fluid collection. CBD, portal vein & splenic vein size are normal.

Spleen: size & parenchymal echotexture is normal with no focal mass lesion seen.

Pancreas: show evidence of normal size & parenchymal echotexture with no evidence of focal mass lesion.

Aorta: show normal caliber & no evidence of paraortic mass lesion seen.

Right kidney: show evidence of normal size, position, corticomedullary differentiation & parenchymal echotexture. No evidence of obvious calcification or hydronephrosis seen. No evidence of focal solid or cystic mass lesion seen.

Left kidney: show evidence of normal size, position, corticomedullary differentiation & parenchymal echotexture. No evidence of obvious calcification or hydronephrosis seen. No evidence of focal solid or cystic mass lesion seen.

Bladder: partial filled, walls are normal & no evidence of stone or mass seen.

Prostate: show evidence of normal size & parenchymal echotexture. No evidence of ascitis or abnormal bowel loops seen.

Size cm app

Right Kidney	Left Kidney	Prostate Vol/Wt cc/gms.
10.2X3.16	10.5X4.35	12.4

COMMENTS:

No abnormality detected.


 Thanks for reference
 PRAKATIK THAKKAR
 M.B.B.S., D.M.R.D.

PATIENT NAME	SEX	REFERRER
JMAR G PARMAR	M	BODY PR

USG AB

ence of normal size, parenchyma seen. Normal hepatic vessels seen.

contracted with no evidence of stones. No evidence of pericholecystic fluid. Spleenic vein size are normal.

Renchymal echotexture is normal. No evidence of normal size & shape.

Normal caliber & no evidence of stones.

Normal evidence of normal echotexture. No evidence of focal solid or cystic mass lesions.

Normal evidence of normal echotexture. No evidence of focal solid or cystic mass lesions.

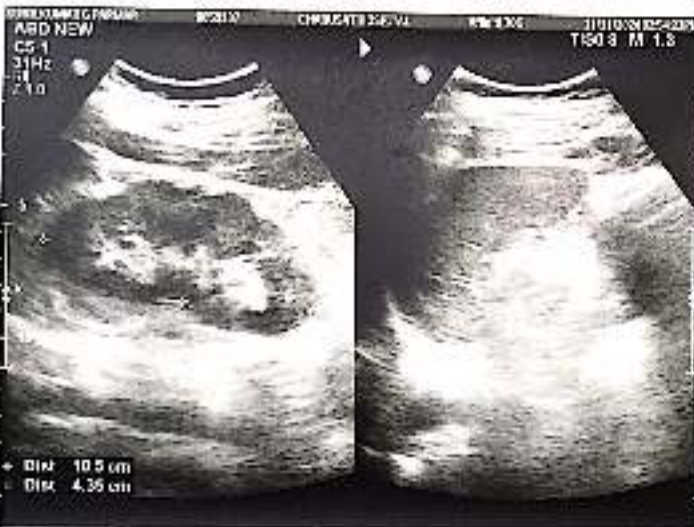
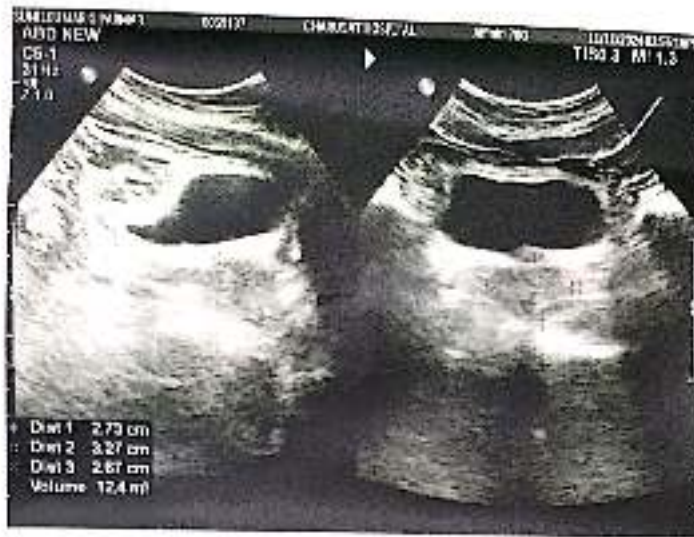
Normal, walls are normal & no evidence of stones.

Normal evidence of normal size & position. No evidence of abnormal bowel loops.

Pr
Vol
cc/3
1.35
12.

sted.

Anand 388 421 (Gu) India.
@charusa.org / www.charusathc



DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
11-11-2024	SUNILKUMAR G PARMAR	M	BODY PROFILE	X-RAY

X-ray CHEST PA view.

No evidence of consolidation or infiltration seen involving both lungs.

Costophrenic sinuses are clear.

Vascular shadows are normal on both sides.

Hilar shadows show evidence of normal size, position & opacity.

Heart & aortic shadows show evidence of normal position & size.

Position of domes of diaphragm is normal. Bony cage show no abnormality.

COMMENTS:

NO EVIDENCE OF ABNORMALITY DETECTED.



Thanks for reference
DR. KIRTI C THAKKAR
M.B.B.S, D.M.R.D