




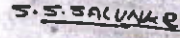
बैंक ऑफ बड़ौदा
Bank of Baroda



नाम सुचिता सुनिल साळुंके
Name Suchita Sunil Salunke

कर्मचारी कूट क्र.
E. No. SS169631


जारीकर्ता प्राधिकारी
Issuing Authority


S. S. SALUNKE

धारक के हस्ताक्षर
Signature of Holder

S. S. SALUNKE

मिलने पर, कृपया निम्नलिखित को लौटाएं
अंचल कार्यालय (बृहन्मुंबई) पो ऑ बॉ नं 1674,
3 बालचंद हीराचंद मार्ग, बैलार्ड पियर, मुंबई 400 001, भारत
दूरध्वनि: 91-22 2261 0341, 4206 0780

If found, please return to
Zonal Office (Greater Mumbai), P.O. Box no. 1674
3, Walchand Hirachand Marg, Ballard Pier, Mumbai 400 001, India.
Phone 91-22 2261 0341, 4206 0780

रक्त समूह / Blood Group A+ve
पहचान चिह्न / Identification Marks



Apollo Clinic Vashi <apolloclinicvashi@gmail.com>

Health checkup booking summery on 24/12/2022

1 message

Customer Care :Mediwhoel : New Delhi <customercare@mediwheel.in>
To: "apolloclinicvashi@gmail.com" <apolloclinicvashi@gmail.com>

Fri, Dec 23, 2022 at 7:46 PM

Dear Team

Please note the following health checkup booking summery on 24/12/2022

Member Name	Member Age	Package Name	Mobile
MS. SALUNKHE SUCHITA SUNIL	44	Medi-Wheel Metro Full Body Health Checkup Female Above 40	9222122048
SUNIL SALUNKE	50	Medi-Wheel Metro Full Body Health Checkup Male Above 40	9222122048

MEDICAL SUMMARY

NAME:	Ms. Sneha Sharma	UHID:	3635
AGE:	47 YRS	DATE OF HEALTHCHECK:	24-12-20
GENDER:	Female		

HEIGHT:	153 cm	MARITAL STATUS:	M
WEIGHT:	49.3 kg	NO OF CHILDREN:	1
BMI:	21.1		

C/O: -

K/C/O: - Hypertension
PRESENT MEDICATION: - Tab Thyroxine 100

P/M/H: Polio.

P/S/H:

ALLERGY: - No

PHYSICAL ACTIVITY: Active/Moderate/Sedentary

H/A: SMOKING:) No
ALCOHOL:) No
TOBACCO/PAN:) No

FAMILY HISTORY FATHER: -) No
MOTHER: -) No

O/E:

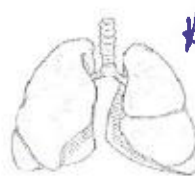
LYMPHADENOPATHY:

BP: 110/80 PULSE: - 72/min

PALLOR/ICTERUS/CYNOSIS/CLUBBING:) No

TEMPERATURE: 36.4 SCARS:

OEDEMA:

S/E: ARSSE
RS: 

P/A: 

CVS: RS2+

Extremities & Spine: - No

ENT: - No

CNS: Cerebral, otherwise

Skin: - No

Vision:

	Without Glass		With Glass	
	Right Eye	Left Eye	Right Eye	Left Eye
FAR :				
NEAR :				
COLOUR VISION:				

OPHTHALMIC EVALUATION

UHID No.: 3635

Date: 24/12/22

Name: Mrs Suchita Age: 46 Gender: Male/Female

Without Correction: PCP - Biocap ✓

Distance: Right Eye _____ Left Eye _____

Near : Right Eye _____ Left Eye _____

With Correction :

Distance: Right Eye 6/6 Left Eye 6/6

Near : Right Eye NG Left Eye NG

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance	+1.5	+0.25	175°			+1.5	+0.25	180°		
Near	+3.0					+3.0				

Progressive

Colour Vision : NO (BL)

Anterior Segment Examination : NO (BL)

Pupils : NO (BL)

Fundus : _____

Intraocular Pressure : 12 mmHg (BL)

Diagnosis : glasses

Advice : _____

Re-Check on 1 year (This Prescription needs verification every year)

DR. RUCHIRA SHARMA
M. S. (OPHTH)
CONSULTING OPHTHALMOLOGIST
& MICRO SURGEON
REG. No.: 3262 / 09 / 02

Dr. _____
(Consultant Ophthalmologist)

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

DENTAL CHECKUP

Name: <u>Suchita. Salunke</u>	MR NO: <u>3635.</u>
Age/Gender: <u>47/F</u>	Date: <u>24/12/22</u>

Medical history: Diabetes Hypertension

EXAMINATION	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Calculus & Stains				
Mobility			++	++
Caries (Cavities)				
a) Class 1 (Occlusal)	6, 7	7	7	7
b) Class 2 (Proximal)				
c) Class 5 (Cervical)				
Faulty Restoration				
Faulty Crown				
Fractured Tooth				
Root Pieces				
Impacted Tooth				
Missing Tooth				
Existing Denture		6	6	6

TREATMENT ADVISED:

TREATMENT	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Restoration / Filling				
Root Canal Therapy				
Crown				
Extraction				

Oral Prophylaxis: Scaling & polishing


Orthodontic Advice for Braces: Yes / No

Prosthetic Advice to Replace Missing Teeth: Denture Bridge Implant

Oral Habits: Tobacco Cigarette Others since ___ years

Advice to quit any form of tobacco as it can cause cancer.

Other Findings: _____


 Dr. Namrata Patil
 MDS, Pedodontics.
 Reg: A-16738

Name: Rani Sushita

Age: 47y Sex: F

UHID No.:

Date: 21/12/2020

UTI, F, PUA (ETAD)

to gynaec consultation

↳ no menstrual complaints

UTI - PUA (5)

Rst :- nil.

ac-far

sterile.

cup / AD

RIA - 3H

no culture.

R

Dr. 4



Apollo Clinic
VASHI

■ Consultation

■ Diagnostics

■ Health Check-Ups

■ Dentistry

Name : Mrs. Suchita Sunil Salunkhe Gender : Female Age : 47 Years
 UHID : FVAH 3635 Bill No : Lab No: V-2662-19
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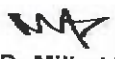
TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

CBC (Complete Blood Count)-WB (EDTA)

Haemoglobin(Colorimetric method)	9.9	g/dl	11.5 - 15
RBC Count (Impedance)	4.16	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	31.6	%	35 - 55
MCV:(Calculated)	75.8	fl	78 - 98
MCH:(Calculated)	23.8	pg	26 - 34
MCHC:(Calculated)	31.3	gm/dl	30 - 36
RDW-CV:	17.6	%	10 - 16
Total Leucocyte/WBC count(Impedance)	5740	/cumm.	4000 - 10500
Neutrophils:	57	%	40 - 75
Lymphocytes:	37	%	20 - 40
Eosinophils:	04	%	0 - 6
Monocytes:	02	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	3.13	Lakhs/c.mm	1.5 - 4.5
MPV	10.1	fl	6.0 - 11.0
Peripheral Smear (Microscopic examination)	Hypochromasia(+),Microcytosis(+),Anisocytosis(+)		
RBCs:			
WBCs:	Normal		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter. Manual diff performed.		

Vasanti Gondal
Entered By

Ms Kaveri Gaonkar
Verified By


Dr. Milind Patwardhan
M.D(Pathologist)
Chief Pathologist

End of Report
Results are to be correlated clinically

• ANDHERI • COLABA • NASHIK • VASHI

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

ESR(Westergren Method)

Erythrocyte Sedimentation Rate:- **24** mm/1st hr 0 - 20

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TEST


RESULTS

Blood Grouping (ABO & Rh)-WB(EDTA) Serum

ABO Group: :A:
Rh Type: **Positive**
Method : Tube Agglutination (forward and reverse)

Shweta Unavane
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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin : 5.6 %
 Normal <5.7 %
 Pre Diabetic 5.7 - 6.5 %
 Diabetic >6.5 %
 Target for Diabetes on therapy < 7.0 %
 Re-evaluation of therapy > 8.0 %

Mean Blood Glucose : 114.02 mg/dL

Correlation of A1C with average glucose

A1C (%)	Mean Blood Glucose (mg/dl)
6	126
7	154
8	183
9	212
10	240
11	269
12	298

Method High Performance Liquid Chromatography (HPLC).

INTERPRETATION

- * The HbA1c levels correlate with the mean glucose concentration prevailing in the course of Pts recent history (apprx 6-8 weeks) & therefore provides much more reliable information for glycemia control than the blood glucose or urinary glucose.
- * This Methodology is better than the routine chromatographic methods & also for the daibetic pts.having HEMOGLBINOPATHIES OR UREMIA as Hb variants and uremia does not INTERFERE with the results in this methodology.
- * It is recommended that HbA1c levels be performed at 4 - 8 weeks during therapy in uncontrolled DM pts.& every 3 - 4 months in well controlled daibetics .
- * Mean blood glucose (MBG) in first 30 days (0-30)before sampling for HbA1c contributes 50% whereas MBG in 90 - 120 days contribute to 10% in final HbA1c levels

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	100	mg/dL	Normal < 100 mg/dL Impaired Fasting glucose : 101 to 125 mg/dL Diabetes Mellitus : \geq 126 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)
Post Prandial Plasma Glucose :	98	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : \geq 200 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)

Method : Hexokinase

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Lipid Profile- Serum			
S. Cholesterol(Oxidase)	180	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	148	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	29.6	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	<u>28.7</u>	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	121.7	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	<u>6.3</u>		3.5 - 5
Ratio of LDL/HDL	<u>4.2</u>		2.5 - 3.5

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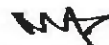
TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LFT(Liver Function Tests)-Serum

S.Total Protein (Biuret method)	7.26	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.27	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.99	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.43		0.9 - 2
S.Total Bilirubin (DPD):	0.28	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.12	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.16	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P): 20		U/L	5 - 36
S.ALT (SGPT) (IFCC Kinetic with P5P): 11		U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic): 103		U/L	35 - 105
S.GGT(IFCC Kinetic): 9		U/L	07 - 32

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY	
S.Urea(Urease Method)	13.3 mg/dl	10.0 - 45.0
BUN (Calculated)	6.2 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.41 mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	15.12	9:1 - 23:1
S.Uric Acid(Uricase Method)	3.1 mg/dl	2.4 - 5.7

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
------	---------	-------	-------------------------------

Thyroid (T3,T4,TSH)- Serum

Total T3 (Tri-iodo Thyronine) (ECLIA)	1.80	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	114.9	nmol/L	66 - 181 nmol/L
TSH (Thyroid-stimulating hormone) (ECLIA)	5.26	□IU/mL	Euthyroid : 0.35 - 5.50 □IU/mL Hyperthyroid : < 0.35 □IU/mL Hypothyroid : > 5.50 □IU/mL

Grey zone values observed in physiological/therapeutic effect.

Note:

T3 :

1. Decreased values of T3 (T4 and TSH normal) have minimal Clinical significance and not recommended for diagnosis of hypothyroidism.
2. Total T3 and T4 values may also be altered in other conditions due to changes in serum proteins or binding sites ,Pregnancy, Drugs (Androgens,Estrogens,O C pills, Phenytoin) etc. In such cases Free T3 and free T4 give corrected Values.
3. Total T3 may decrease by < 25 percent in healthy older individuals

T4 :

1. Total T3 and T4 Values may also be altered in other condition due to changes in serum proteins or binding sites, Pregnancy Drugs (Androgens,Estrogens,O C pills, Phenytoin), Nerphrosis etc. In such cases Free T3 and Free T4 give Corrected values.

TSH :

1. TSH Values may be transiently altered because of non thyroidal illness like severe infections,liver disease, renal and heart failure. Severe burns, trauma and surgery etc.
2. Drugs that decrease TSH values e,g L dopa, Glucocorticoids.
3. Drugs that increase TSH values e.g. Iodine,Lithium, Amiodarone

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

URINE REPORT

PHYSICAL EXAMINATION

QUANTITY	60	mL
COLOUR	Pale Yellow	
APPEARANCE	Clear	Clear
SEDIMENT	Absent	Absent

CHEMICAL EXAMINATION(Strip Method)

REACTION(PH)	5.0	4.6 - 8.0
SPECIFIC GRAVITY	1.010	1.005 - 1.030
URINE PROTEIN	Absent	Absent
URINE SUGAR(Qualitative)	Absent	Absent
KETONES	Absent	Absent
BILE SALTS	Absent	Absent
BILE PIGMENTS	Absent	Absent
UROBILINOGEN	Normal(<1 mg/dl)	Normal
OCCULT BLOOD	Trace	Absent
Nitrites	Absent	Absent

MICROSCOPIC EXAMINATION

PUS CELLS	1 - 2 / hpf	0 - 3/hpf
RED BLOOD CELLS	2 - 3 / hpf	Absent
EPITHELIAL CELLS	2 - 3 /hpf	3 - 4/hpf
CASTS	Absent	Absent
CRYSTALS	Absent	Absent
BACTERIA	Absent	Absent

Anushka Chavan
Entered By

Ms Kaveri Gaonkar
Verified By


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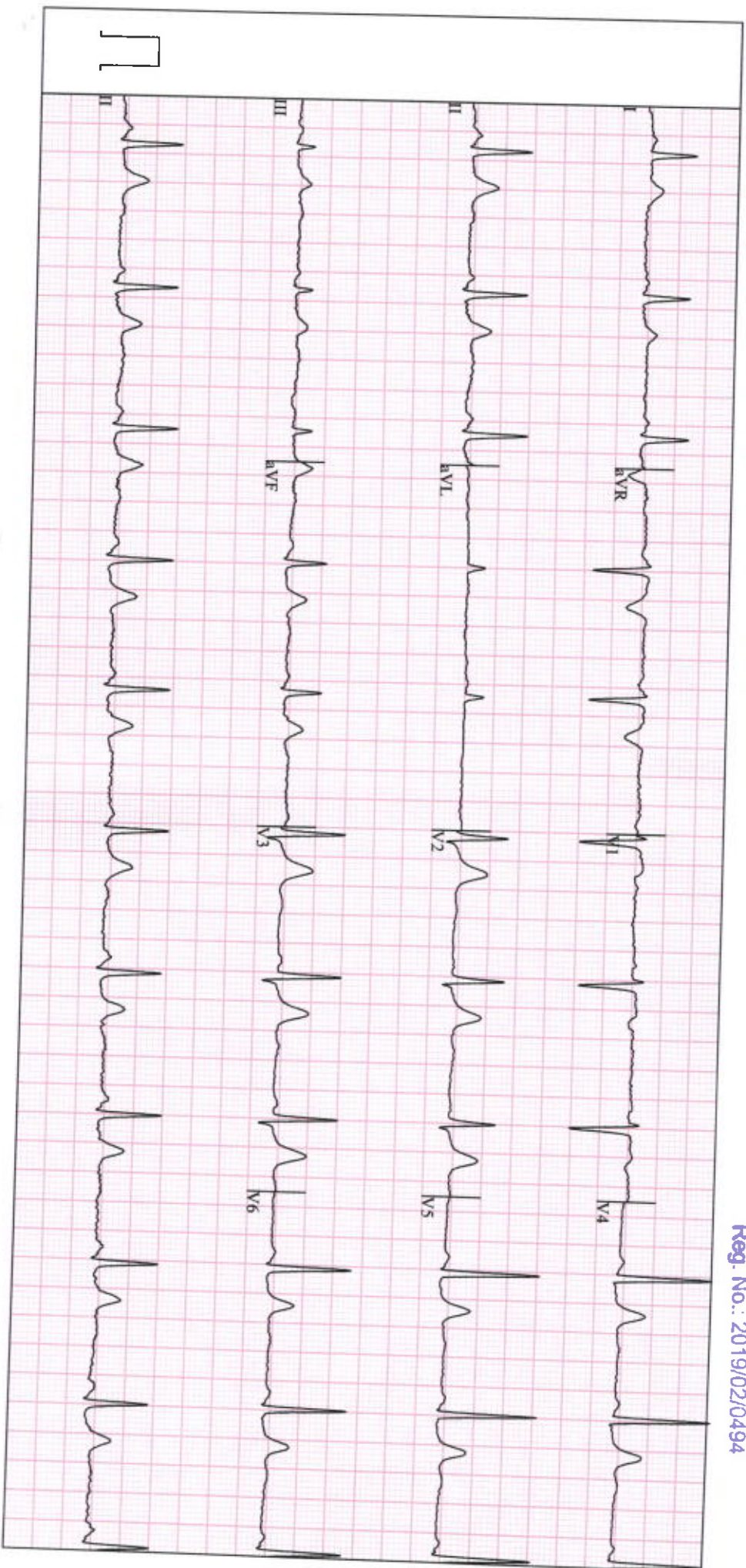
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QRS : 72 ms
QT/QTcBaz : 378 / 383 ms
PR : 118 ms
P : 84 ms
RR/PP : 962 / 967 ms
P / QRS / T : 65 / 43 / 58 degrees

Normal sinus rhythm
Normal ECG

*Normal sinus rhythm.
No significant S-T changes.*

DR. RISHI A. BHARGAVA
MD, DM (Cardiology)
CONSULTANT CARDIOLOGIST
Reg. No.: 2019/02/0494



PATIENT'S NAME	SUCHITA S SALUNKHE	AGE :- 47 Y/M
UHID	3635	DATE :- 24-12-22

2D Echo and Colour doppler report

All cardiac chambers are normal in dimension

No obvious resting regional wall motion abnormalities (RWMA)

Interatrial and Interventricular septum – Appears Normal

Valves – Structurally normal

Good biventricular function.

IVC is normal.

Pericardium is normal.

Great vessels - Origin and visualized proximal part are normal.

No coarctation of aorta.

Doppler study

Normal flow across all the valves.

No pulmonary hypertension.

No diastolic dysfunction.

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Measurements

Aorta annulus	20 mm
Left Atrium	30 mm
LVID(Systole)	20 mm
LVID(Diastole)	36 mm
IVS(Diastole)	09 mm
PW(Diastole)	09 mm
LV ejection fraction.	55-60%

Conclusion

- Good biventricular function
- No RWMA
- Valves – Structurally normal
- No diastolic dysfunction
- No PAH

Dasgupta

Performed by: Dr. Anirban Dasgupta
D.N.B. Internal Medicine, Diploma Cardiology (PGDCC-IGNOU).

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PATIENT'S NAME	SUCHITA SALUNKHE	AGE :- 47 y/F
UHID	3635	26 Dec 2022

X-RAY BILATERAL MAMMOGRAMS

Film screen mammography of the breasts was performed using low radiation dose. Medio-lateral oblique and cranio - caudal projections were obtained.

Indication: Screening mammogram.

Comparison: No previous mammogram is available for comparison.

Findings-

ACR B-Mild scattered dense fibroglandular parenchyma.

Right breast:

RT lower lateral breast show 2 ill defined radiodense lesions.

Left breast:

No dominant mass, suspicious calcifications or architectural distortion is seen.

IMPRESSION-

Suggest sonomammography . ACR category 3.

Recommendation: Routine screening follow up and regular self breast examinations.

DISCLAIMER: Not all breast abnormalities show up on mammography. The false negative rate of mammography is approximately 10%. The management of a palpable abnormality must be based on clinical grounds. If you detect a lump or any other change in your breast before your next screening mammogram, consult your doctor immediately.

Lexicon: ACR BIRADS category 1- negative for malignancy; ACR BIRADS category 2- benign finding; ACR BIRADS category 3- probably benign finding, 98 % benign and 2 % risk of malignancy; ACR BIRADS category 4a- low suspicion of malignancy, 2-10% risk of malignancy; ACR BIRADS category 4b- intermediate suspicion of malignancy, 10-50% risk of malignancy; ACR BIRADS category 4c- high suspicion of malignancy, 50-95 % risk of malignancy; ACR BIRADS category 5- highly suggestive of malignancy, > 95% risk of malignancy; ACR BIRADS category 6- biopsy proven malignancy



DR. DISHA MINOCHA
DMRE (RADIOLOGIST)

• ANDHERI • COLABA • NASHIK • VASHI

PATIENT'S NAME	SUCHITA SALUNKHE	AGE: 47Y/ F
UHID NO	3635	DATE: 24/12/2022

X-RAY CHEST PA VIEW

OBSERVATION:

- Bilateral lung fields are clear.
- Both hila are normal.
- Bilateral cardiophrenic and costophrenic angles are normal.
- The trachea is central.
- Aorta appears normal.
- The mediastinal and cardiac silhouette are normal.
- Soft tissues of the chest wall are normal.
- Bony thorax is normal.

IMPRESSION:

- No significant abnormality seen.



Dr. Ashwin Y.
M.D. (Radio-Diagnosis)

PATIENT'S NAME	SUCHITA S SALUNKHE	AGE :- 47 y/F
UHID	3635	24 Dec 2022

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size, (14.1 cm) shape and echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepato-petal flow. No evidence of intra-hepatic biliary duct dilatation.

Gall Bladder appears well distended with normal wall thickness. There is no calculus or pericholecystic collection. CBD appears normal.

Visualised parts of head & body of PANCREAS appear normal.

SPLEEN is normal in size (10.0 cm) and echotexture. No focal lesion seen. Splenic vein is normal.

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis or calculi or mass seen.

URINARY BLADDER is well distended; no e/o wall thickening or mass or calculi seen. Post-void residual urine volume is not significant.

UTERUS is anteverted and is normal in size, shape and echotexture; No focal lesion seen. It measures 7.8 x 3.1 x 5.7 cm; ET measures 7.4 mm.

Right ovary volume 8-9 ml. Dominant follicle.
14 x 11 mm left ovary volume:8-10 ml

Both ovaries are normal in size, shape and position.

Visualised BOWEL LOOPS appear normal. There is no free fluid seen.

IMPRESSION -

- No significant abnormality detected.

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE. THE CONTENTS OF THIS REPORT REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.


Dr. Ashwin Y.
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• ANDHERI • COLABA • NASHIK • VASHI