

NAME:	Ms. Priya Bhatnagar	UHID:	5467
AGE:	27 YRS	DATE OF HEALTHCHECK:	11/2/2020
GENDER:	Female		

HEIGHT:	166 cm	MARITAL STATUS:	M
WEIGHT:	59.00 kg	NO OF CHILDREN:	1
BMI:	21.4		

C/O: -

K/C/O:

PRESENT MEDICATION: - Tab - atorvastatin
Tab - metformin

P/M/H: - no

P/S/H: - no

ALLERGY: - no

PHYSICAL ACTIVITY: Active / Moderate / Sedentary

H/A: SMOKING: -

FAMILY HISTORY FATHER: - IAD

ALCOHOL: -

MOTHER: -

TOBACCO/PAN: -

O/E: -

LYMPHADENOPATHY: -

BP: 110/80 PULSE: - 100/min

PALLOR/ICTERUS/CYNOSIS/CLUBBING: -

TEMPERATURE: - SCARS: -

OEDEMA: -

S/E: -

P/A: -

RS: -



CVS: -

Extremities & Spine: -

CNS: -

ENT: -

Skin: -

Vision:

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

• ANDHERI • COLABA • NASHIK • VASHI

Name: Mrs. Priya

Age: 27y Date of Health check-up: 11/3/23

Findings and Recommendation:

Findings:-

- P_1 away bulb
- ~~PT~~ Pericardial effusion
- Plat + 1
- Ure Bact +

Recommendation:-

- Gy nax 400 / Penicillin
- Repeat 2D Echo = 2 weeks
- Repeat Ure = P_1 / 1 week
- Repeat CBC = 1 week
- D.D / Exam

Signature:

Consultant -



DR. ANIRBAN DASGUPTA
MBBS, D.N.B MEDICINE
DIPLOMA CARDIOLOGY
MMC-2005/02/0920

OPHTHALMIC EVALUATION

UHID No.: 5467 Date: 11/3/23
 Name: Mrs Priya Age: 28 Gender: Male / Female

Without Correction :

Distance: Right Eye 6/6 Left Eye 6/6
 Near : Right Eye 26 Left Eye 26

With Correction :

Distance: Right Eye _____ Left Eye _____
 Near : Right Eye _____ Left Eye _____

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance										
Near										

Colour Vision : Normal (BU)

Anterior Segment Examination : _____

Pupils : _____

Fundus : NO (BU)

Intraocular Pressure : 12 mm (BU)

Diagnosis : _____

Advice : _____

Re-Check on 6 mths (This Prescription needs verification every year)

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

Dr. [Signature]
 (Consultant Ophthalmologist)

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

Name: Mrs Priya Age: 28y Sex: F UHID No.: Date: 11/3/2025

28yrs, P1L1
Aspapnic

u/h top - 27/2/2025

As+:- nil

u - fair
atechle

u - good
RA - 3H
u - normal

RA - papnic
u - normal

Dr. 



Apollo Clinic
VASHI

- Consultation
- Diagnostics
- Health Check-Ups
- Dentistry

DENTAL CHECKUP

Name: Mrs. Priya	MR NO:
Age/Gender : 27/F	Date: 11/3

Medical history: Diabetes Hypertension

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

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: NA

DR. SNEHA NITIN GADHIYA
 BDS (BACHELOR OF DENTAL SURGERY)
 REG NO: 39708

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Name : Mrs. Priya Gender : Female Age : 27 Years
UHID : FVAH 5467 Bill No : Lab No : V-1350-23
Ref. by : SELF Sample Col.Dt : 11/03/2023 9:10
Barcode No : 8363 Reported On : 11/03/2023 18:21

TEST RESULTS BIOLOGICAL REFERENCE INTERVAL


HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)

Haemoglobin(Colorimetric method)	12.6	g/dl	11.5 - 15
RBC Count (Impedance)	4.38	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	38.1	%	35 - 55
MCV:(Calculated)	87	fl	78 - 98
MCH:(Calculated)	28.8	pg	26 - 34
MCHC:(Calculated)	33	gm/dl	30 - 36
RDW-CV:	13.8	%	10 - 16
Total Leucocyte count(Impedance)	7590	/cumm.	4000 - 10500
Neutrophils:	62	%	40 - 75
Lymphocytes:	33	%	20 - 40
Eosinophils:	03	%	0 - 6
Monocytes:	02	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	1.41	Lakhs/c.mm	1.5 - 4.5
MPV	12.7	fl	6.0 - 11.0
ESR(Westergren Method)	06	mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination)			
RBCs:	Normochromic, Normocytic		
WBCs:	Normal		
Platelets	Large platelets, Reduced, Manual platelet count = 1.45 Lakhs/c.mm		

Note: Test Run on 5 part cell counter. Manual diff performed.

Alsaba Shaikh
Entered By

Ms Kaveri Gaonkar
Verified By

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Milind Patwardhan
M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

Name : Mrs. Priya Gender : Female Age : 27 Years
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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin : 4.9 %
 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 : 93.93 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 then the routine chromatographic methods & also for the daibetic pts.having HEMOGLBINOPATHIES OR UREMIA as Hb varaints 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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 Dr. M. D. Patwardhan
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 M.D(Path)

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

Lipid Profile- Serum

S. Cholesterol(Oxidase)	166	mg/dL	Desirable < 200 Borderline: >200-<240 Undesirable: >240
S. Triglyceride(GPO-POD)	83	mg/dL	Desirable < 150 Borderline: >150-<499 Undesirable: >500
S. VLDL:(Calculated)	16.6	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	60.1	mg/dL	Desirable > 60 Borderline: >40-<59 Undesirable: <40
S. LDL:(calculated)	89.3	mg/dL	Desirable < 130 Borderline: >130-<159 Undesirable: >160
Ratio Cholesterol/HDL	<u>2.8</u>		3.5 - 5
Ratio of LDL/HDL	<u>1.5</u>		2.5 - 3.5

Mrunal Gurav
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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LFT(Liver Function Tests)-Serum

S.Total Protein (Biuret method)	7.15	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.45	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.7	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.65		0.9 - 2
S.Total Bilirubin (DPD):	1.20	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.36	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.84	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	19	U/L	5 - 32
S.ALT (SGPT) (IFCC Kinetic with P5P):	18	U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic):	92	U/L	35 - 105
S.GGT(IFCC Kinetic):	12	U/L	07 - 32

Mrunal Gurav
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Verified By

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Dr. Milind Patwardhan
M.D(Path)
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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

Thyroid (T3,T4,TSH)- Serum

TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Total T3 (Tri-iodo Thyronine) (ECLIA)	1.80	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	94.79	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	1.68	□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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Dr. Milind Patwardhan
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End of Report
Results are to be correlated clinically



Indira Health And Lifestyle Private Limited.
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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

URINE REPORT

PHYSICAL EXAMINATION

QUANTITY	30	mL	
COLOUR	Yellow		
APPEARANCE	Hazy		Clear
SEDIMENT	Present		Absent

CHEMICAL EXAMINATION(Strip Method)

REACTION(PH)	7.0	4.6 - 8.0
SPECIFIC GRAVITY	1.005	1.005 - 1.030
URINE ALBUMIN	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	Absent	Absent
Nitrites	Absent	Absent

MICROSCOPIC EXAMINATION

PUS CELLS	4 - 5 / hpf	0 - 3/hpf
RED BLOOD CELLS	Nil /HPF	Absent
EPITHELIAL CELLS	20 - 25 / hpf	3 - 4/hpf
CASTS	Absent	Absent
CRYSTALS	Absent	Absent
BACTERIA	Present(+)	Absent

Anushka Chavan
Entered By

Ms Kaveri Gaonkar
Verified By

Dr. Milind Patwardhan
M.D(Path)

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End of Report
Results are to be correlated clinically

Priya
5467

27 Years

Female

11/03/2023 11:22:12

Apollo Clinic
1st Flr, The Emerald, Sector-12,
Vashi, Mumbai-400703.

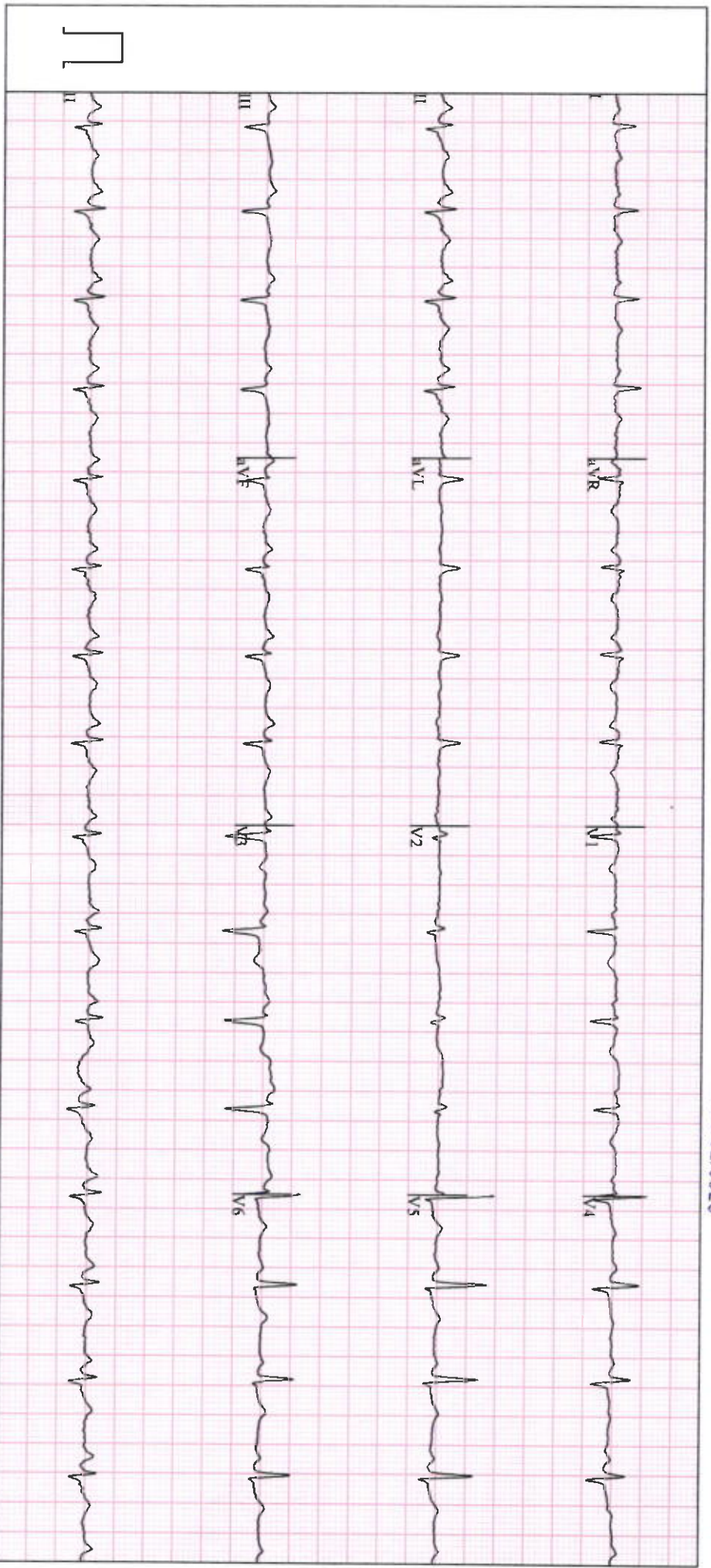
98 bpm
--/-- mmHg

QRS : 72 ms
QT / QTcBaz : 336 / 428 ms
PR : 146 ms
P : 120 ms
RR / PP : 612 / 612 ms
P / QRS / T : 64 / -25 / 46 degrees

Normal sinus rhythm
Nonspecific ST and T wave abnormality
Abnormal ECG

- LAD
- Coarctate aorta

DR. ANIRBAN DASGUPTA
M.B., B.S., D.N.B. Medicine
Diploma Cardiology
MMC - 2005/02/0920



GE MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 50 Hz Unconfirmed 4x2.5x3 25 R1 1/1

PATIENT'S NAME	PRIYA BHATIA	AGE :- 27 Y/F
UHID	5467	DATE :- 11-03-23

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: Minimal pericardial effusion, clinical correlation necessary.

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.

Measurements

Aorta annulus	19 mm
Left Atrium	32 mm
LVID(Systole)	18 mm
LVID(Diastole)	46 mm
IVS(Diastole)	08 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).

PATIENT'S NAME	PRIYA	AGE :- 27 y/F
UHID NO	5467	11 Mar 2023

X-RAY CHEST PA VEIW

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. CHHAYA S. SANGANI
CONSULTANT SONOLOGIST
Reg No. 073826

• ANDHERI • COLABA • NASHIK • VASHI

PATIENT'S NAME	PRIYA BHATIA	AGE :-27Y/F
UHID	5467	11 Mar 2023

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size, 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, 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.

RIGHT KIDNEY measures 9.8 x 4.0 cm. **LEFT KIDNEY** measures 9.8 x 4.5 cm.

URINARY BLADDER is well distended; no e/o wall thickening or mass or calculi seen.

UTERUS is anteverted and is normal in size, shape and echotexture; No focal lesion seen. It measures 6.6 x 4.6 x 4.0 cm; ET measures 6.8 mm.

Left ovary is normal in size, shape and position. Right ovary is mildly enlarged in size.

RIGHT OVARY measures : 4.3 x 2.6 x 3.2 cm (Vol: 22.1 ml),

LEFT OVARY measures : 3.0 x 2.5 x 1.6 cm (Vol: 6.8 ml).

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

IMPRESSION –

- Mild bulky right ovary.
- No other 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.CHHAYA S. SANGANI
CONSULTANT SONOLOGIST
Reg: No. 073826

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