

| | | | |
|----------------|--------------------------------|---------|-------------------|
| Patient's name | : RAKSHA SAILESHKUMAR UPADHYAY | Age/Sex | : 59 Years/Female |
| Referred by | : Self | Reg. No | : 3343 |
| Date | : 31/07/2021 | Mobile | : 9429544500 |
| Patient's Id | : RU5 | Ref ID. | : |

Fitness Certificate

GENERAL EXAMINATION

Height (cms) : 148

Weight (kgs) : 67.8

Blood Pressure : 120/70 mmHg

Pulse : 70/Min

No Clubbing/Cynosis/Pallor/Pedel Oedem

Systemic Examination:

Cardio vascular System - S1,S2 Normal, No Murmur

Respiratory system - AEBE

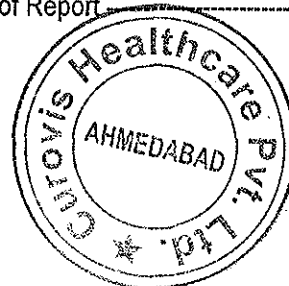
Central Nervous System - No FND

Abdomen - Soft, Non Tender, No Organomegaly

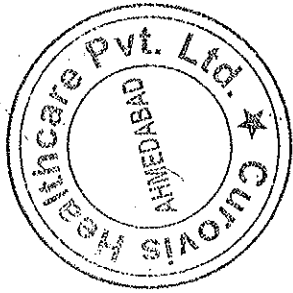
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Dr Jinen M Shah
DNB (Medicine)FCCS (USA)



DR. Jihen M Shah
Registration No: G-20693

R, S, Upadhyay

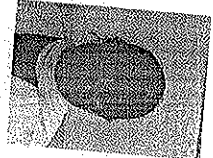

3629 1419 9497

આધાર - સામાન્ય માણસનો અધિકાર

ભારત સરકાર
Government of India

ઉપાધ્યાય રણી
Upadhyay Raksha

જન્મ તારીખ / DOB : 13/06/1962
શ્રી / Female



| | |
|--|----------------------------------|
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| Referred by : Self | Reg. No : 3343 |
| Date : 31/07/2021 | Mobile : 9429544500 |
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HEMOGRAM REPORT

Performed on 5-Part Fully Auto Hematology Analyzer SIEMENS ADVIA 2120i)

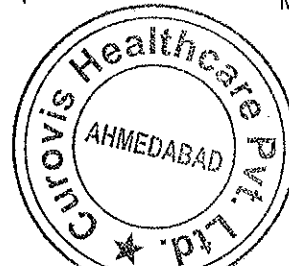
| Test | Result | Unit | Biological Reference Interval |
|---|--------------------------------------|--------------------------|-------------------------------|
| Sample Type: | EDTA | | |
| Haemoglobin: | 10.1 | gm/dL | 12.5 - 16.0 |
| Total WBC Count: | 8100 | /microlitre | 4000 - 10500 |
| Platelets Count: | 350000 | /microlitre | 1,50,000 - 4,50,000 |
| Differential Count: | | | |
| Neutrophils: | 51 | % | 40-80 |
| Lymphocytes: | 43 | % | 20-40 |
| Eosinophils: | 04 | % | Upto 6 |
| Monocytes: | 02 | % | 2-10 |
| Basophils: | 00 | % | <1-2 |
| RBC indices: | | | |
| RBC Count: | 3.93 | *10 ⁶ /microL | 3.8 - 4.8 |
| HCT: | 31.3 | % | 36 - 46 |
| MCV: | 79.6 | fL | 83 - 101 |
| MCH: | 25.7 | pg | 27-32 |
| MCHC: | 32.3 | % | 31.5-34.5 |
| RDW: | 12.6 | % | 11.6 - 14.0 |
| Erythrocytes Sedimentation Rate(ESR): (By AUTO ESR-10, USA) | | | |
| ESR 1st Hr: | 12 | mm | 2 - 20 mm in 1Hr. |
| Thick Smear Preparation: | | | |
| Haemoparasite: | Malarial parasites are not seen. | | |
| Peripheral Smear Examination: | | | |
| RBCs: | Mild Microcytic & Hypochromic. | | |
| Platelet: | Platelet adequate & normal on smear. | | |

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


Dr. KEYUR Patel
M.B.DCP

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Patient's name : RAKSHA SAILESHKUMAR UPADHYAY Age/Sex : 59 Years/Female
Referred by : Self Reg. No : 3343
Date : 31/07/2021 Mobile : 9429544500
Patient's Id : RU5 Ref ID. :

GLYCOSYLATED HAEMOGLOBIN (HbA1C) ESTIMATION

| Test | Result | Unit | Biological Reference Interval |
|--|--------|------|--|
| Sample Type: EDTA | | | |
| Glycosylated Haemoglobin (HbA1C) | 6.39 | % | Pre-Diabetic (Adult): 5.7 - 6.4 Diabetic (Adult): >6.5 Therapeutic goal for glycemic control: <7.0 |
| Mean Blood Glucose Level (An average of 2 -3 Months) | 136.69 | | |

Method : HPLC on D-10, Bio-Rad,USA

INTERPRETATION:

- * Blood sample can be drawn at any time. Fasting is not required.
- * Reflects average blood sugar levels for the 2 to 3 months period before the test.
- * Provides information for evaluating diabetic treatment modalities and tracks control of blood glucose of particular value in diabetic children, diabetics in whom the renal threshold for glucose is abnormal, unstable insulin dependent diabetics where blood sugars vary markedly from day to day.
- * High value in poorly controlled DM and moves towards normal in patients with optimal control.

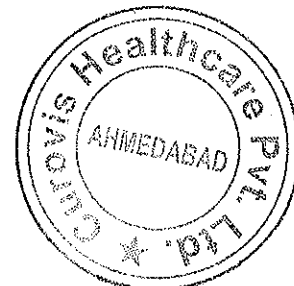
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Dr. KEYUR Patel
M.B.DCP

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| Date : 31/07/2021 | Mobile : 9429544500 |
| Patient's Id : RU5 | Ref ID. : |

LIPID PROFILE

(Performed on Semi Auto Chemistry Analyzer BeneSphera)

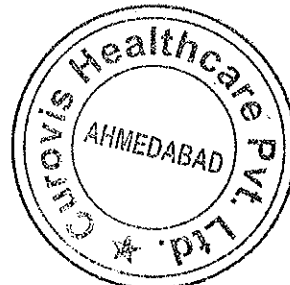
| Test | Result | Unit | Biological Reference Interval |
|---|---------------|-------------|--|
| Sample Type: Fasting Serum | | | |
| S.Cholesterol (Oxidase Peroxidase) | 210 | mg/dL | < 200 Desirable 200-239 Boderline High > 240 High |
| S.HDLC (Direct) (Phosphotungsstic Acid) | 74.0 | mg/dL | < 40 Low > 60 High |
| S.Triglyceride (GPO-POD) | 88.8 | mg/dL | < 150 mg/dl Normal 150-199 Boderline High 200-499 High > 500 Very High |
| S.VLDL (Calculated) | 17.76 | mg/dL | 10-40 Normal |
| S.LDLC (Calculated) | 118.24 | mg/dL | < 100 Optimal 100-129 Near to above optimal 130-159 Boderline high 160-189 High >190 Very High |
| S.Cholesterol / HDLC Ratio (Calculated) | 2.84 | | < 4 Normal 4-6 Borderline 6-8 Risklevel > 8 High Risk |
| S.LDLC / HDLC Ratio (Calculated) | 1.6 | | < 3 Normal 3-4 Borderline 4-6 Risk Level > 6 High Risk |
| Cholesterol / HDLC Ratio (Calculated) | 2.84 | | < 3.5 Normal |
| Triglyceride / HDLC Ratio (Calculated) | 1.2 | | < 2 Normal > 4 Risk Level > 6 High Risk |
| Non HDLC (Calculated) | 136 | | < 130 Normal 130 - 159 Near Normal 160 - 189 Borderline 190 - 219 Risklevel > 220 High Risk |

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


Dr. KEYUR Patel
M.B.DCP

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| Referred by : Self | Reg. No : 3343 |
| Date : 31/07/2021 | Mobile : 9429544500 |
| Patient's Id : RU5 | Ref ID. : |

LIVER FUNCTION TEST

(Performed on Fully Auto DRY Chemistry Analyzer VITROS-250)

| Test | Result | Unit | Biological Reference Interval |
|--------------------------------------|--------|-------|-------------------------------|
| Sample Type: Serum | | | |
| S.Bilirubin | | | |
| Total Bilirubin | 0.36 | mg/dl | 0 - 1.2 |
| (Azobilirubin) | | | |
| Conjugated Bilirubin | 0.10 | mg/dl | 0 - 0.4 |
| (Dual Wavelength spectrophotometric) | | | |
| Unconjugated Bilirubin | 0.26 | mg/dl | 0.0 - 1.1 |
| (Dual Wavelength spectrophotometric) | | | |
| S.G.P.T. (ALT) | 14.2 | IU/L | 0 - 49 |
| (Kinetic with Pyridoxal 5-Phosphate) | | | |
| S.G.O.T. (AST) | 18.8 | IU/L | Up to 46 |
| (Kinetic with Pyridoxal 5-Phosphate) | | | |
| S.ALP (Alkaline Phosphatase) | 471.3 | U/L | 64 - 306 |
| (4-Nitrophenyl phosphate) | | | |
| S.Protein | | | |
| Total Protein | 6.98 | gm/dl | 6.3 - 8.2 |
| (Biuret) | | | |
| Albumin | 4.48 | gm/dl | 3.5 - 5.2 |
| (BCG) | | | |
| Globulin | 2.5 | gm/dl | 1.9 - 3.5 |
| (Calculated) | | | |
| Albumin Globulin Ratio | 1.79 | | |
| S.GammaGT | 29.4 | IU/L | 12-43 |
| (L-Gamma Glutamyl-4-Nitroanilide) | | | |

SERUM LDH LEVEL

| Test | Result | Unit | Biological Reference Interval |
|--|--------|------|-------------------------------|
| Sample Type: Serum | | | |
| LDH Activity (Lactate Dehydrogenase): | 187.9 | U/L | 120 - 246 |
| Pyruvate to lactate Kinetic Method | | | |

#Tests Performed on Fully Auto DRY Chemistry Analyzer VITROS-250

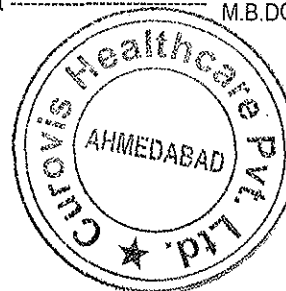
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M.B.DCP

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Referred by : Self Reg. No : 3343
Date : 31/07/2021 Mobile : 9429544500
Patient's Id : RU5 Ref ID. :

BLOOD GROUP

Sample Type: EDTA
ABO Group : "O"
Rh Type : Positive

RENAL FUNCTION TEST

(Performed on Fully Auto DRY Chemistry Analyzer VITROS-250)

| Test | Result | Unit | Biological Reference Interval |
|--|--------|-------|--------------------------------------|
| Sample Type: Serum | | | |
| S.Urea (Urease with indicator dye) | 17.2 | mg/dl | Male: 19.6-43.6 Female: 15.2-37.0 |
| S.Creatinine (Enzymatic) | 0.60 | mg/dL | 0.55 - 1.30 |
| S.Uric Acid (Uricase) | 6.06 | mg/dL | Male: 3.5-8.5 Female: 2.5-6.2 |

BLOOD GLUCOSE LEVEL

| Test | Result | Unit | Biological Reference Interval |
|---|----------|-------|-------------------------------|
| Sample Type: | Flouride | | |
| Fasting Blood Glucose (Hexokinase) Collection Time: Collection Time: | 92.3 | mg/dl | 70-110 |
| Post Prandial Blood Glucose (2 Hrs) (Hexokinase) | 100.9 | mg/dl | 80-140 |

Tests Performed on Fully Auto DRY Chemistry Analyzer VITROS-250

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

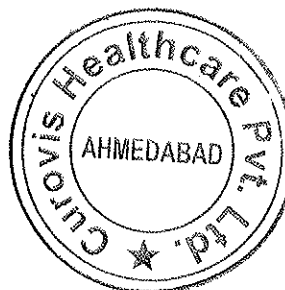

Dr. KEYUR Patel
M.B.DCP

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Patient's Id : RU5 Ref ID. :

THYROID FUNCTION TEST
(by CLIA on SIEMENS ADVIA Centaur XP)

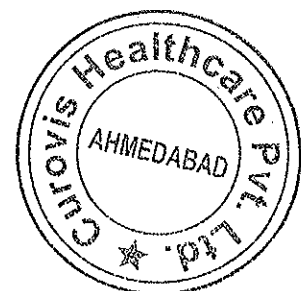
| Test | Result | Unit | Biological Reference Interval |
|---|--------|-----------|--|
| Sample Type: Serum | | | |
| S.T3 (Total Triiodothyronine by CLIA) | 1.66 | ng/mL | 1 - 23 Months: 1.17 - 2.39 2 - 12 Years: 1.05 - 2.07 13 - 20 Years: 0.86 - 1.92 Adult: 0.6 - 1.81 |
| S.T4 (Total Thyroxine by CLIA) | 11.10 | mcg/dL | 3.2 - 12.6 |
| S.TSH (Thyroid Stimulating Hormone by CLIA) | 5.433 | microU/mL | 0 -12 Yrs: 0.77 - 5.64 12-19 Yrs: 0.75-3.69 19-100 Yrs: 0.35 -5.50 |

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


Dr. KEYUR Patel
M.B.DCP

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| Date : 31/07/2021 | Mobile : 9429544500 |
| Patient's Id : RU5 | Ref ID. : |

URINE ROUTINE ANALYSIS

Sample Type: Fresh Urine

Physical Examination

(Naked Eye Observation)

| | Result | Biological Ref. Value |
|------------|---------------|------------------------------|
| Amount | 10 ml | >10 ml |
| Colour | Pale Yellow | Pale Yellow |
| Appearance | Clear | Clear |

Chemical Examination

| | | |
|--|--------|-------------|
| pH (Dip stick) | 6.5 | 4.5-8.0 |
| Specific Gravity (Bromothymol Blue) | 1.025 | 1.002-1.030 |
| Albumin (Tetrabromopheno) | Absent | Absent |
| Glucose (Specific Glucose Oxidase/Peroxidase) | Absent | Absent |
| Bilirubin (Azo-coupling reaction) | Absent | Absent |
| Acetone (Sodium Nitroprusside Reaction) | Absent | Absent |
| Urobilinogen (Modified Ehrlich Reaction) | Absent | Absent |
| Nitrites (Diazotization Reaction) | Absent | Absent |

Microscopic Examination

(After centrifugation at 1500 RPM for 10min./hpf)

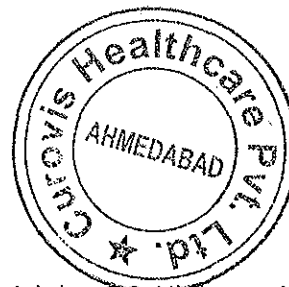
| | | |
|-----------------------|--------|--------|
| Pus Cells(WBCs) | Absent | Absent |
| Red Blood Cells(RBCs) | Absent | Absent |
| Epithelial cells | Absent | |
| T.Vaginals | Absent | Absent |
| Spermatozoa | Absent | Absent |
| Casts | Absent | Absent |
| Crystals | Absent | Absent |
| Amorphous Material | Absent | Absent |

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


Dr. KEYUR Patel
M.B.DCP

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Eye Check - Up

RIGHT EYE

SP: +0.25
CY: -0.50
AX: 69

LEFT EYE

SP: -3.25
CY: -0.75
AX: 84

| | Without Glasses | With Glasses |
|------------------|------------------------|---------------------|
| Right Eye | 6/6 | N.A |
| Left Eye | 6/18 | N.A |

Near Vision: Right Eye -N/6, Left Eye - N/6

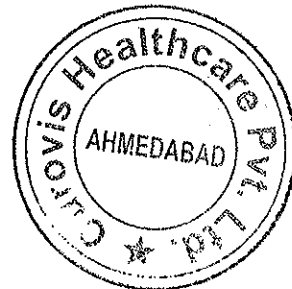
Fundus Examination: Within Normal Limits.

Colour Vision: Normal

Comments: Catract surgery in RT eye.

Dr.Kejal Patel
MB,DO(Ophth)

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Electrocardiogram

Findings

Normal Sinus Rhythm.

Within Normal Limit.

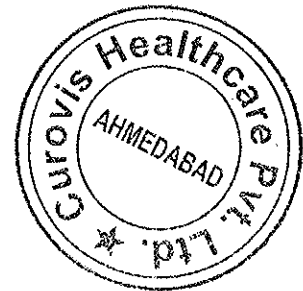
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Dr Jinen M Shah
DNB (Medicine) FCCS (USA)

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Raksha
Upadhyay
15

59 years
148 cm / 68 kg
Female

HR 70/min

Intervals:
RR 858 ms
P 92 ms
PR 148 ms
QRS 124 ms
QT 420 ms
QTc 457 ms
(Bazett)

Axis:

P 39°
QRS 109°
T 24°
P (II) 0.16 mV
S (VI) -0.19 mV
R (V5) 0.65 mV
Sokol. 1.00 mV



CURROVIS HEALTHCARE

R. S. Upadhyay

10 mm/mV
25 mm/s
0.05 25 Hz FS0 555 585 31-07-2024 12:25:15

| | | | |
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2D Echo Colour Doppler

OBSERVATION:

2 D Echo and color flow studies were done in long and short axis, apical and Sub costal views.

1. Normal LV size. No RWMA at rest.
2. Normal RV and RA. Concentric LVH.
3. All Four valves are structurally normal.
4. Good LV systolic function. LVEF = 55%.
5. Stage I diastolic dysfunction.
6. Trivial TR. Mild MR. No AR.
7. Mild PAH. RVSP = 40 mmHG.
8. Intact IAS and IVS.
9. No Clot, No Vegetation.
10. No pericardial effusion.

CONCLUSION

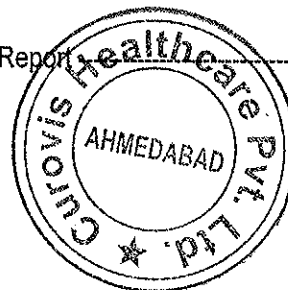
1. Normal LV size with Good LV systolic function.
2. Concentric LVH . Stage I diastolic dysfunction
3. Trivial TR with Mild PAH. Mild MR. No AR
4. No RWMA at rest.

This echo doesn't rule out any kind of congenital cardiac anomalies.

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

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DNB (Medicine)FCCS (USA)

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X RAY CHEST PA

Both lung fields appear clear.

No evidence of any active infiltrations or consolidation.

Cardiac size appears within normal limits.

Both costo-phrenic angles appear free of fluid.

Both domes of diaphragm appear normal.

Bony thorax appears normal.

COMMENT: No significant abnormality is detected.

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

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Dr. Jaimin Shah
DMRD
Consultant Radiologist

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USG ABDOMEN

Liver appears normal in size , show homogenous parenchymal echoy. No evidence of focal solid or cystic lesion seen. No evidence of dilatation of intra-hepatic biliary or portal radicals. PV is normal in caliber.

Gall bladder is normally distended. No evidence of calculus or mass seen. Gall bladder wall thickness appears normal.

Pancreas Visualized portion appears normal in size and echopattern. No evidence of focal lesions.

Spleen appears normal in size & echopattern. No evidence of focal lesions.

Both kidneys are normal in size, shape and position. C.M. differentiation on both sides is maintained. No evidence of hydronephrosis, calculus or solid mass on either side.

Urinary bladder is partially distended. No evidence of calculus or mass.

Uterus appears normal. No adnexal mass is seen.

No evidence of free fluid in peritoneal cavity.

No evidence of para-aortic lymph adenopathy.

No evidence of dilated small bowel loops.

COMMENTS :

NO SIGNIFICANT ABNORMALITY DETECTED.

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

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Dr. Jaimin Shah
DMRD
Cunsaltant Radiologist

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| Patient's Id | : RU5 | Ref ID. | : |

BILATERAL MAMMOGRAM :-

Dedicated lowdose digital mammography with Craniocaudal and media lateral oblique view was performed.

Fibroglandular tissue replaced by fatty tissue .
No evidence of clustered microcalcification .
No evidence of mass or architectural distortion is seen.
No evidence of skin thickening or nipple retraction is seen.
No evidence of axillary lymphadenopathy.

COMMENT :

- Fibroglandular tissue partially replaced fatty tissue, post menopausal changes..No significant abnormality detected. (BIRADS - I).
- No direct or indirect sign of malignancy seen.

BIRADS Categories :

- 0 Need imaging evaluation.
I **Negative**
II Benign finding
III probably benign finding.
IV Suspicious abnormality.
V Highly suggestive of malignancy.

The false negative mammography is approximately 10%. Management of a palpable abnormality must be based upon clinical grounds.

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

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DMRD
Consultant Radiologist

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Gynaec Check Up

Name: Raksha Upadhyay

Children: 2 child

Deliveries: Normal, 1
C.S - 1

Last Child: In 1991

Abortions: NO

Periods: NO

LMP: NO

Menopause: Since 20 yr

G. Condition: (B)

P/A: (B)

S/E: (B)

P/V: (U)

P/R: (R)

Impression:

(P)

Weight: 67.8

BP: 120/80 mmHg

Breasts: NO.

Pap smear: Not done before

Previous Medical H/O:

HTN since 2013
medicine taken
Regular

Previous Surgical H/O:

ke-s.c.s. In 1991

Doctor Signature

Date & Time

