

NAME:	Mrs. Kamika	UHID:	
AGE:	32	DATE OF HEALTHCHECK:	9/9/2023
GENDER:	F		

HEIGHT:	154 cm	MARITAL STATUS:	M
WEIGHT:	80.1 kg	NO OF CHILDREN:	1
BMI:	33.8		

C/O: Weakness &

K/C/O:

PRESENT MEDICATION: - Tab Calcium

P/M/H: - No

P/S/H: - LSC

ALLERGY: - No

PHYSICAL ACTIVITY: Active/ Moderate/ Seder.tary

H/A: SMOKING:

FAMILY HISTORY FATHER: -) NAD

ALCOHOL:) No

MOTHER: -) NAD

TOBACCO/PAN:) No

O/E:

LYMPHADENOPATHY:) No

BP: 96/60 mmHg PULSE: - 68/min

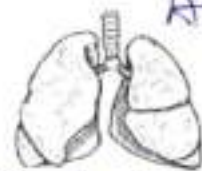
PALLOR/ICTERUS/CYNOSIS/CLUBBING:) No

TEMPERATURE: n SCARS:

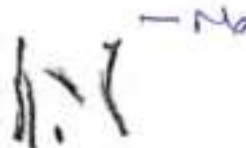
OEDEMA:

S/E:

RS:



P/A:



CVS:) No

Extremities & Spine: - No

CNS: Coarse, unilateral respiratory

ENT: -) NAD

Skin: -) NAD

Vision:

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

Findings and Recommendation:

Findings:-

Lipid Profile - TC - 208mg/dl
VLDL - 41.6 //
HDL - 37.4 mg/dl
urine $\left(\frac{R}{M} \right)$ Pus Cells - 5-6/hpf.

USG . ge I Fatty liver
Bulky uterus \bar{c}
fundal fibroid

Recommendation:-

consult Gynaecologist
weight reduction

DR. PRADNYA DANI
(M.B.B.S)
Reg. No. 87541

Signature:

Consultant -

OPHTHALMIC EVALUATION

UHID No.: _____

Date: 9/9/23

Name: Miss Karika Age: 32 Gender: Male/Female

Without Correction: myopia cataract

Distance: Right Eye _____ Left Eye _____

Near : Right Eye _____ Left Eye _____

With Correction :

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

Near : Right Eye _____ Left Eye 26

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance	<u>-2.0</u>					<u>-2.25</u>	<u>-0.25</u>	<u>135</u>		
Near										

Colour Vision : N70

Anterior Segment Examination : N70 (B)

Pupils : _____

Fundus : Myopic fundus.

Intraocular Pressure : 16 mm (B)

Diagnosis : low glasses

Advice : _____

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

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

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

DENTAL CHECKUP

Name: Mrs. Kanika	MR NO:
Age/Gender : 32yrs / F	Date: 09/09/23

Medical history: Diabetes Hypertension NRH

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				
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: no treatment required

Ali

Name: Ms Kanika Age: 32 Sex: F UHID No.: _____ Date: 9/9/23

32 years / married / P, 4 (Luo).

h/o Breast fibroadenoma 1yr back

Comp. 31/8/2023

O/K

Gcfair

Mfibrils

lulse - 72/mi

WS - NAD

PA: soft NT

Pls Co y healthy

(PAP smear taken).

Plu E reports

Adw

Sonomammography.

Dr. Trupti Shinde
DR. TRUPTI VIJAY SHINDE
MBBS, M.S. (OBS & GYNAE)
REG. NO.: 2014/07/3301



Apollo Clinic
VASHI

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

Name : Mrs. Kanika Gender : Female Age : 32 Years
UHID : FVAH 8357. Bill No : Lab No : V-974-23
Ref. by : SELF Sample Col.Dt : 09/09/2023 09:40
Barcode No : 8220 Reported On : 09/09/2023 18:02

TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

PLASMA GLUCOSE

Fasting Plasma Glucose :	87	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 :	112	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

Vasanti Gondal
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Ms Kaveri Gaonkar
Verified By



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

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End of Report
Results are to be correlated clinically

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin : 5.0 %
 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 : 96.8 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

Alsaba Shaikh
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Ms Kaveri Gaonkar
Verified By


Dr. Munde Patwardhan
Page 6 of 10
M.D(Path)
Chief Pathologist

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

Lipid Profile- Serum

S. Cholesterol(Oxidase)	163	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	208	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	41.6	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	37.4	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	84	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	4.4		3.5 - 5
Ratio of LDL/HDL	2.2		2.5 - 3.5

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


LFT(Liver Function Tests)-Serum

S.Total Protein (Biuret method)	6.98	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.41	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.57	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.72		0.9 - 2
S.Total Bilirubin (DPD):	0.32	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.13	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.19	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P): 15		U/L	5 - 32
S.ALT (SGPT) (IFCC Kinetic with P5P): 9		U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic): 74		U/L	35 - 105
S.GGT(IFCC Kinetic): 15		U/L	07 - 32

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Dr. Milind Patwardhan
M.D(Path)
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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
BIOCHEMISTRY		
S.Urea(Urease Method)	24.7 mg/dl	10.0 - 45.0
BUN (Calculated)	11.52 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.50 mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	23.0	9:1 - 23:1
S.Uric Acid(Uricase Method)	3.8 mg/dl	2.4 - 5.7

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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)	1.93	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	117.1	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	2.51	□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
M.D(Path)

Page 9 of 9 Chief Pathologist

End of Report

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

URINE REPORT

PHYSICAL EXAMINATION

QUANTITY	50	mL	
COLOUR	Pale Yellow		
APPEARANCE	Slightly Hazy		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 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	5 - 6 / hpf		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	10 - 12 / hpf		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Present(+)		Absent

Neha More
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Verified By



Dr. Milind Patwardhan
M.D(Path)

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Chief Pathologist

End of Report
Results are to be correlated clinically

Kanika
8357

09.09.2023 13:25:45
Aprilia Clinic
1st Flr, The Emerald, Sector-12,
Vashi, Mumbai-400703.

65 bpm
-- / -- mmHg

32 Years Female

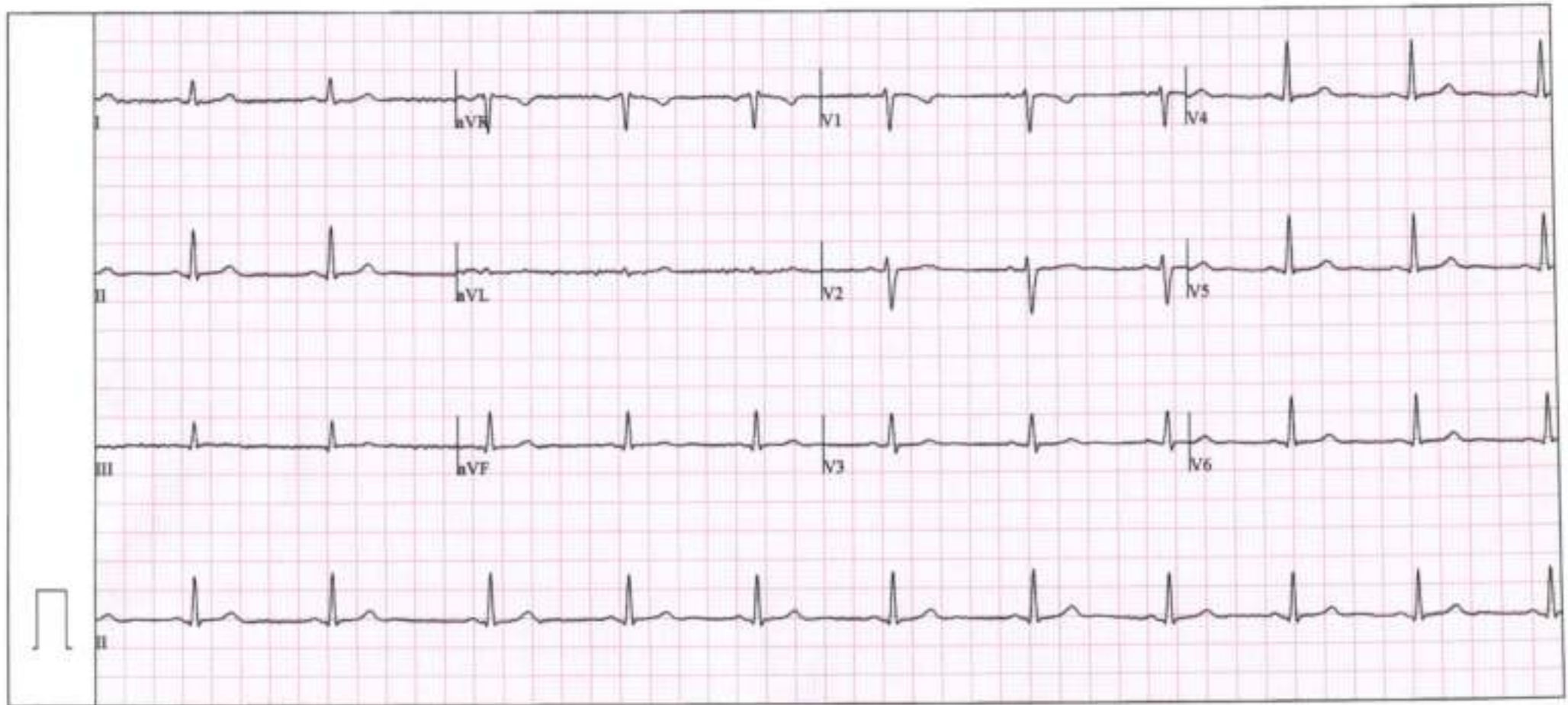
NORMAL ECG

QRS : 78 ms
QT / QTcBaz : 384 / 399 ms
PR : 132 ms
P : 94 ms
RR / PP : 922 / 923 ms
P / QRS / T : 28 / 59 / 40 degrees

Normal sinus rhythm with sinus arrhythmia
Normal ECG

W-L


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



PATIENT'S NAME	KANIKA	AGE :- 32 Y/F
UHID	8357	DATE :- 09-09-23

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

Mild MR , Trivial TR

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.

Measurements

Aorta annulus	20 mm
Left Atrium	31 mm
LVID(Systole)	21 mm
LVID(Diastole)	37 mm
IVS(Diastole)	10 mm
PW(Diastole)	10 mm
LV ejection fraction.	55-60%

Conclusion

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



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

PATIENT'S NAME	KANIKA	AGE :- 32Y/F
UHID	8357	DATE :- .11 Sep. 23

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. DISHA MINOCHA
DMRE (RADIOLOGIST)

PATIENT'S NAME	KANIKA	AGE :- 32Y/F
UHID	8357	9 Sep 2023

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size, shape and shows bright 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 11.5 x 4.1 cm. **LEFT KIDNEY** measures 12.2 x 5.3 cm.

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

UTERUS is anteverted and is enlarged in size, normal shape and echotexture; No focal lesion seen. It measures 8.1 x 5.3 x 4.1 cm; ET measures 6.4 mm. A fundal fibroid measuring 22 x 15 mm.

Both ovaries are normal in size, shape and position.

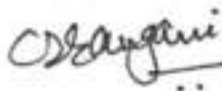
RIGHT OVARY measures : 2.9 x 1.9 cm, **LEFT OVARY** measures : 2.9 x 2.0 cm.

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

IMPRESSION -

- Grade I fatty liver.
- Bulky uterus with fundal fibroid.
- 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

• ANDHERI • COLABA • NASHIK • VASHI

