OPD ASSESSMENT FORM

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Name Mr. Vikas J Trivedi Age.Sex 34/M MR.No. S143370

Doctor Dr. Hardik Shroff Date 23-09-23

Ht : _____ Wt. : _____ Temp : _____ Pulse : _____ BP : _____

SPO2 : _____ Post of walk SPO2 : _____

Chief Complaints :

No complaint

Drug / Food Allergy :

Prior Medication Reviewed : Yes ☐ No ☐

On examination :

RE AW. Clg WNL

VA c 6/6 6/6

Past History :

Fundii (Central) BE WNL

Provisional Diagnosis :

Vit ophthalmic

Nutritional Assessment :

- ☐ Obese
- ☐ Well nourished
- ☐ Mild- moderate nourished
- ☐ Severely mal-nourished

Treatment and further Advices :
(Write in Capital Letters)

Rx

Investigation advised :

—

Dr. Hardik Shroff
DOMS, DNB (Ophthalmology)
Regd. No. G-28902
SUNSHINE GLOBAL HOSPITAL
Piplod, SURAT.

Follow Up : SOS **Date :** _____ **Signature**

In case of emergency Please report to Emergency Department of Hospital OR
Call : 75748 49465, 0261-4111000

OPD ASSESSMENT FORM

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Name Mr. Vikash J. Trivedi Age.Sex 34/M. MR.No. S143370.

Doctor Dr. Anang Desai Date 23/9/23.

Ht : _____ Wt. : _____ Temp : _____ Pulse : _____ BP : _____

SPO2 : _____ Post of walk SPO2 : _____

Chief Complaints :

- Routine dental checkup

Drug / Food Allergy :

Prior Medication Reviewed : Yes ☐ No ☐

On examination :

- Stain deposits

Past History :

Provisional Diagnosis :

Nutritional Assessment :

- ☐ Obese
- ☐ Well nourished
- ☐ Mild- moderate nourished
- ☐ Severely mal-nourished

Treatment and further Advices :
(Write in Capital Letters)

Rx

1) Scaling

Investigation advised :

D. P-desai

SURAT ★ SUNSHINE HOSPITAL ★

Follow Up : **Date :** _____ **Signature**

In case of emergency Please report to Emergency Department of Hospital OR
Call : 75748 49465, 0261-4111000

DOC. No.	SGHS/FMT/OPD002	DOI	14/06/2014	Rev. No.	0.1

OPD ASSESSMENT FORM

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Name Mr. Vikas J. Trivedi Age.Sex 34/M MR.No. 5143370

Doctor Dr. Krunal Gajjar Date 23-9-23

Ht : 173cm Wt. : 91.3kg Temp : _____ Pulse : 84 b/min BP : 126/83 MM Hg

SPO2 : 97-1 Post of walk SPO2 : _____

Chief Complaints :

C/O Dyspepsia.

Drug / Food Allergy :

NO.

Prior Medication Reviewed : Yes ☐ No ☐

On examination :

RS } NAD.
CVS }

Past History :

— N.S —

Provisional Diagnosis :

Nutritional Assessment :

- ☐ Obese
- ☑ Well nourished
- ☐ Mild- moderate nourished
- ☐ Severely mal-nourished

Treatment and further Advices :
(Write in Capital Letters)

Rx

Investigation advised :

→ cap. Somprass-D (40) x (15) days.

→ Tab. Ritagut (400) 1-0-1 x (10) days

Dr. Krunal Gajjar
M.B.B.S., MD (MEDICINE)
CONSULTANT PHYSICIAN
Reg. No. G-20422
SUNSHINE GLOBAL HOSPITAL
SURAT.

Follow Up : **Date :** _____ **Signature**

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MR. NO!- S143370

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ECHO CARDIOGRAPHIC REPORT

Patient's Name : Mr. Vikas J. Trivedi Date : 23/09/23 11:30AM

Sex : M Age : 34 Ref. by Dr. : Medicwheel Done by Dr. Surendra Singh

LV Size :

LVEF : 67 % (VISUAL)

DIASTOLIC DYSFUNCTION :

LVH :

RWMA : ANTERIOR WALL
ANTERIOR SEPTUM
IVS
LV APEX
POSTERIOR WALL
LATERAL WALL
INFERIOR WALL

NORMAL ECHO

MITRAL VALVE :

AORTIC VALVE

PULMONARY VALVE :

TRICUSPID VALVE

PAH :

PASP :

RA :

LA :

RV :

IVC :

IAS :

IVS :

IVS (s)	cm	LV(s)	cm	PW (s)	cm	LVEF =	67 %
IVS (d)	cm	LV (d)	cm	PW (d)	cm	FS =	%

CONCLUSION :

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MR No.	: **S143370**	**Collection Date**	: 23/09/2023 9:49AM
Patient Name	: **Mr. Vikas Jayantilal Trivedi**	**Age**	: 34 Y **Sex** : Male
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 23/09/2023 12:14 PM

HAEMATOLOGY

Parameter	Result	Units	Normal Range
CBC with ESR			
HAEMOGLOBIN	15.4	gm/dl	13.0 - 17.0
PCV	47.1	%	40 - 50
RBC COUNT	**5.60**	mill/cmm	4.5 - 5.5
MCV	84.1	fl	76 - 96
MCH	27.5	pg	26 - 32
MCHC	32.7	%	32 - 36
RDW	12.7	%	11 - 15
PLATELET COUNT	3.35	lacs/cmm	1.5 - 4.5
WBC COUNT	6260	/cmm	4000 - 11000
ESR	05	mm/hr	0 - 10
DIFFERENTIAL WBC COUNT			
NEUTROPHIL	57	%	40 - 70
LYMPHOCYTES	29	%	20 - 40
EOSINOPHILS	**07**	%	1 - 6
MONOCYTES	07	%	2 - 11
BASOPHILS	00	%	0 - 2
PERIPHERAL SMEAR			
RBC MORPHOLOGY	Normochromic Normocytic		
WBC MORPHOLOGY	Eosinophilia		
PLATELET ON SMEAR	Adequate		
HEMOPARASITES	Not Seen		

SYSMEX XN-550

******* End Report *******

Dr. Shobha Choksi
MD, DCP (Pathology)
Reg. No.: G-9074

23/09/2023 12:14PM

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MR No.	: **S143370**	**Collection Date**	: 23/09/2023 9:49AM
Patient Name	: **Mr. Vikas Jayantilal Trivedi**	**Age**	: 34 Y **Sex** : Male
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 23/09/2023 12:09 PM

HAEMATOLOGY

Parameter	Result		Normal Range
BLOOD GROUP & RH FACTOR			
BLOOD GROUP	"O"		
RH FACTOR	POSITIVE		

CLINICAL CHEMISTRY

THYROID FUNCTION TEST [TFT]			
TOTAL T3 (CLIA)	1.48	ng/ml	0.846 - 2.02
TOTAL T4 (CLIA)	7.48	ug/dl	5.1 - 14.0
TSH (CLIA)	2.92	uIU/ml	0.2 - 4.5

Note:-
Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechnism involving concentrations of FT3 (free T3) and FT4 (freeT4). Additionally the hypothalamic tripeptide. thyrotropin releasing hormone (TSH) directly stimulates TSH production. TSH stimulates thyroid cell production and hypertrophy also stimulate the thyroid gland to synthesize and secrete T3 and T4.
Quantification of TSH significant to differentiate primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism. TSH levels are significantly elevated whiled in secondary and tertiary hypothyroidism . TSH levels are low.

******* End Report *******

Dr. Shobha Choksi
MD, DCP (Pathology)
Reg. No.: G-9074

23/09/2023 12:10PM

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MR No.	: **S143370**	**Collection Date**	: 23/09/2023 9:49AM
Patient Name	: **Mr. Vikas Jayantilal Trivedi**	**Age**	: 34 Y **Sex** : Male
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 23/09/2023 12:10 PM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
HBA1C [GLYCOSYLATED HEAMOGLOBIN]			
HbA1C	5.6	%	Non-Diabetic level: <6 Good Control: 6 - 7 Poor Control: 7 - 8 Action Suggested > 8
MEAN BLOOD GLUCOSE	**114.02**	mg/dl	

The test is done on Cobas Integra 400plus-Turbidimetric Inhibition ImmunoAssay
Note:- Criteria for the diagnosis of diabetes HbA1c >/=6.5*
1. HbA1c is important test for the assessment of long term blood glucose control (also called glycemic control).
2. HbA1C reflects mean glucose concentration over pas 6-8 weeks and provides a much better indication of long term glycemic control than blood glucose determination.
3. HbA1C is formed by non-enzymatic reaction between glucose and Hb. This reaction is irreversible and therefor remains unaffected by short term fluctuations in blood glucose levels.
4. Long term complications of diabetes such as retinopathy,nephropathy, and neuropathy are potentially serious and can lead to blindness kidney failure etc.
5. Genetic Variants (Hb-S trait,Hb-C trait) elevated fetal haemoglobin & chemically modified derivatives of haemoglobin (eg carbamylated Hb in patients with renal failure) can affect the accuracy of HbA1C measurement.

ASTING BLOOD SUGAR (FBS)			
FASTING BLOOD GLUCOSE (Hexokinase)	101	mg/dl	74 - 110
FASTING URINE GLUCOSE	Absent		
FASTING URINE KETONE	Absent		

******* End Report *******

Dr. Shobha Choksi
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Reg. No.: G-9074

23/09/2023 12:10PM

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MR No.	: **S143370**	**Collection Date**	: 23/09/2023 9:49AM
Patient Name	: **Mr. Vikas Jayantilal Trivedi**	**Age**	: 34 Y **Sex** : Male
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 23/09/2023 12:11 PM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIPID PROFILE			
SERUM CHOLESTEROL CHOD PAP	**205**	mg/dl	50 - 200
HDL CHOLESTEROL Direct	**35**	mg/dl	40 - 60
LDL CHOLESTEROL Direct	**141.3**	mg/dl	0 - 100
SERUM TRIGLYCERIDE GPO PAP	145	mg/dl	50 - 150
VLDL Calc	29	mg/dl	0 - 30
CHOLESTEROL / HDL RATIO	**5.86**		0 - 5
LDL / HDL RATIO	**4.04**		0 - 3

- LDL Cholesterol level is primary goal for treatment and varies with risk category and assessment.
- Risk assessment from HDL and Triglyceride has been revised. Also LDL goals have changed.
- Details on test interpretation available from the lab.

TEST	NEAR OPTIMAL (Moderate Risk)	BORDER LINE (Risk)	HIGH (Risk)	VERY HIGH
CHOLESTROL	160-199	200-239	240-279	280
HDL	50-59	40-49	< 40	
LDL	100-129	130-159	160-190	>190
TRIGLYCERIDES	150-169	170-199	240-499	>500
CHO/HDL RATIO	3.3-4.4	4.4-11.0	>11.0	
LDL/HDL RATIO	0.5-3.0	3.0-6.0	>6.0	

******* End Report *******

Dr. Shobha Choksi
MD, DCP (Pathology)
Reg. No.: G-9074

23/09/2023 12:11PM

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MR No.	: **S143370**	**Collection Date**	:
Patient Name	: **Mr. Vikas Jayantilal Trivedi**	**Age**	: 34 Y **Sex** : Male
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 23/09/2023 12:12 PM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIVER FUNCTION TEST			
ALKALINE PHOSPHATASE (IFCC)	78	U/L	35 - 130
BILIRUBIN TOTAL Diazo	0.4	mg/dl	0.0 - 1.2
BILIRUBIN DIRECT Diazo	0.2	mg/dl	0.0 - 0.4
BILIRUBIN INDIRECT (Calc)	0.2	mg/dl	0.0 - 0.8
SGPT (IFCC)	26	U/L	5 - 41
SGOT (IFCC)	17	U/L	5 - 40
SERUM TOTAL PROTEIN Biuret	7.2	gm/dl	6.6 - 8.7
SERUM ALBUMIN BCG	4.7	gm/dl	3.5 - 5.2
SERUM GLOBULIN Calc	2.5	gm/dl	1.5 - 3.5
SERUM A/G RATIO Calc	1.88	gm/dl	1.5 - 2.5
SERUM CREATININE			
SERUM CREATININE (JAFFE)	0.8	mg/dl	0.5 - 1.2
SERUM URIC ACID			
SERUM URIC ACID (Uricase)	4.6	mg/dl	3.4 - 7.0
BUN [BLOOD UREA NITROGEN]			
BUN	**7.5**	mg/dl	8 - 23

******* End Report *******

Dr. Shobha Choksi
MD, DCP (Pathology)
Reg. No.: G-9074

23/09/2023 12:12PM

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MR No.	: **S143370**	**Collection Date**	: 23/09/2023 9:49AM
Patient Name	: **Mr. Vikas Jayantilal Trivedi**	**Age**	: 34 Y **Sex** : Male
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 23/09/2023 12:15 PM

CLINICAL PATHOLOGY

Parameter	Result	Normal Range
URINE ROUTINE & MICROSCOPIC EXAMINATION		
TYPE OF SPECIMEN - URINE	Random	
PHYSICAL EXAMINATION		
QUANTITY	**50** ml	
COLOUR	Pale Yellow	
APPEARANCE	Clear	
REACTION (pH)	6.0	
SPECIFIC GRAVITY	1.010	
CHEMICAL EXAMINATION		
PROTEIN	Absent	
GLUCOSE	Absent	
KETONE	Absent	
BILE SALT	Absent	
BILE PIGMENT	Absent	
OCCULT BLOOD	Absent	
NITRITE	Absent	
MICROSCOPIC EXAMINATION		
PUS CELLS	1-2 /hpf	
EPITHELIAL CELLS	1-2 /hpf	
RBC	Absent /hpf	
CASTS	Absent	
CRYSTALS	Absent	
BACTERIA	Absent	
YEAST CELLS	Absent	

******* End Report *******

Dr. Shobha Choksi
MD, DCP (Pathology)
Reg. No.: G-9074

23/09/2023 12:15PM

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PAT. NAME : Vikas Trivedi	**Date** : 23/09/2023
REF. DOCTOR : Hosp. Dr.	**AGE** : 34 Yrs / M
INV. : USG Abdomen & Pelvis	**MR NO.** : S143370

Findings:

Liver is normal in size, shape and shows normal echopattern. No e/o any focal or diffuse lesion noted. Intrahepatic biliary radicals are normal.

Gall bladder is distended and appears normal. No e/o calculus, sludge or mass lesion is seen.
CBD and Portal Vein appears normal is size and calibre.

Pancreas appears normal in size and shows normal echopattern to the extent assessed.
Spleen appears normal in size, shape and homogenous echopattern.

Both kidneys appear normal in size, shape and echopattern. The corticomedullary differentiation is well maintained. No e/o any calculus or hydronephrosis is seen.

Aorta and para-aortic regions appears normal. No e/o any lymphadenopathy.
Urinary bladder appears well distended and normal.
Prostate appears normal in size, shape and echopattern.
No e/o free fluid in abdomen / pelvis.

IMPRESSION:

- **No significant abnormality seen.**

Dr. Pratik R
Consultant Radiologist

Transcribed By: Asha

Date & Time of report: 23/09/2023 – 02:38 PM

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PAT. NAME : Vikas Trivedi	**Date** : 23/09/2023
REF. DOCTOR : Hosp. Dr.	**AGE** : 34 Yrs / M
INV. : Radiograph of Chest PA	**MR NO.** : S143370

Clinical Details: HC

Observation:

- Both the lung fields appears normal.
- Both costophrenic angles appear clear.
- Both the hila appears normal.
- Trachea appears in midline.
- Cardiac size and other mediastinal shadows appears normal.
- Both domes of diaphragm appear normal.
- Bony thorax appears normal.

Dr. Pratik R
Consultant Radiologist

Transcribed By: Asha

Date & Time of report: 23/09/2023 – 02:36 PM

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23-Sep-2023 11:16:00

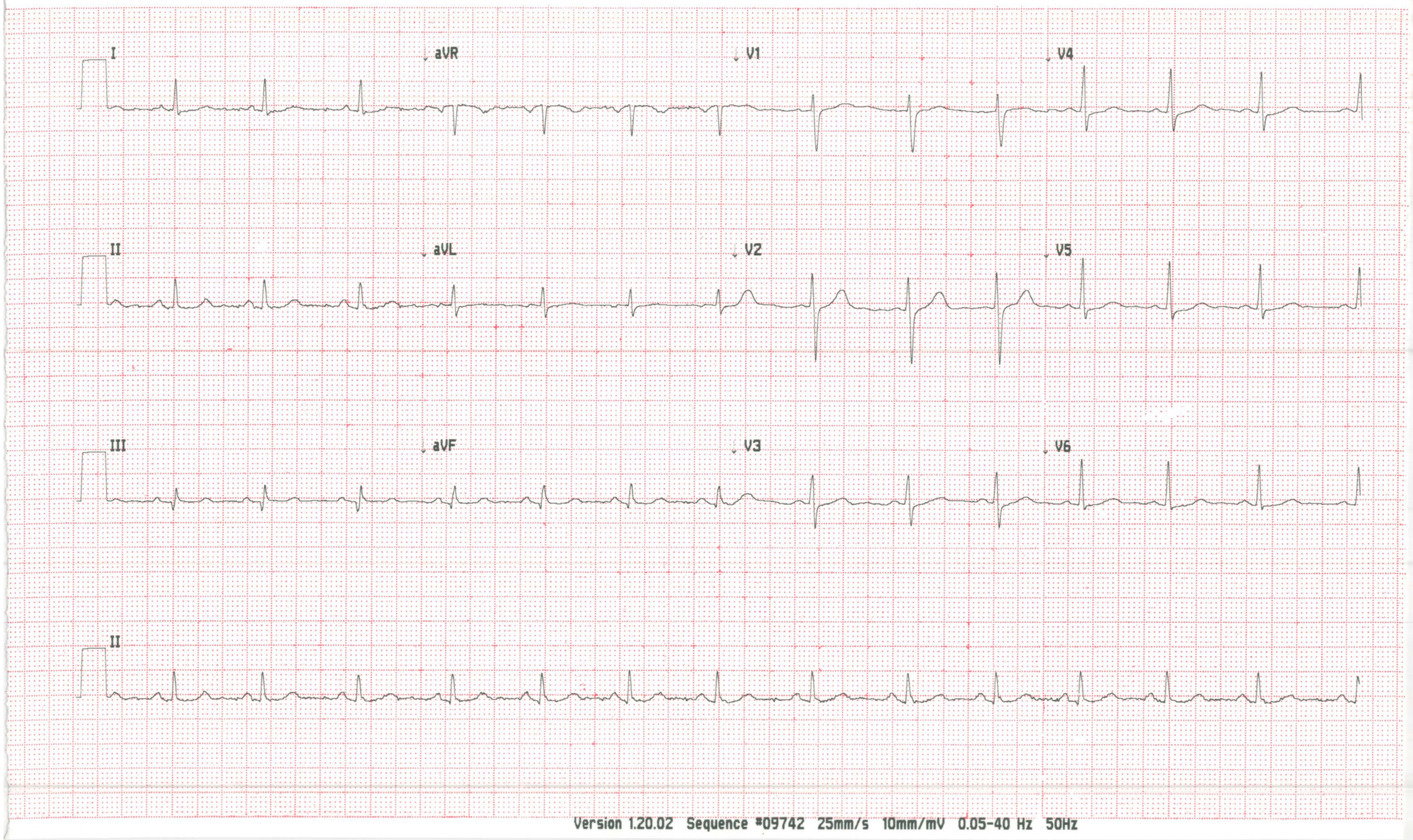
DOB:
yr,

Mr. Vikas J. Trivedi

Vent rate:	82 BPM
PR int:	144 ms
QRS dur:	89 ms
QT/QTc:	343/381 ms
P-R-T axes:	58 41 58

SINUS RHYTHM
NORMAL ECG
INTERPRETATION BASED ON A DEFAULT AGE OF 40 YEARS

Reviewed by _____



Version 1.20.02 Sequence #09742 25mm/s 10mm/mV 0.05-40 Hz 50Hz