



C/O: for refraction

Name: Chunachem Shummet

Date: 11/11/23

Age: 42 Sex: m

OD

OS

UCVA: 6/60P

6/60P

6/60P

SPD 3.0/0.50 X 30
— 6/6

2.75/1.0 X 145
— 6/6

adds +1.0 — NB

+1.0 — NB

(BE) Adv
- Mimedrop, eds
4 times

Dr Shreya Shah
Consultant Ophthalmologist &
Phaco Surgeon
REG NO: G 26895

Sardar Patel Hospital & Heart Institute Chikwadi, Opposite Railway Yard, Ankleshwar - 393001

☎ 02646 - 245883 / 246883 / 247883

25.03.2023 13:09:53
SARDAR PATEL HOSPITAL
CHIKUM
ANKLESH w48

Location:
Order number:
Visit:
Inc. Catton:
Medication 1:
Medication 2:
Medication 3:

Room:

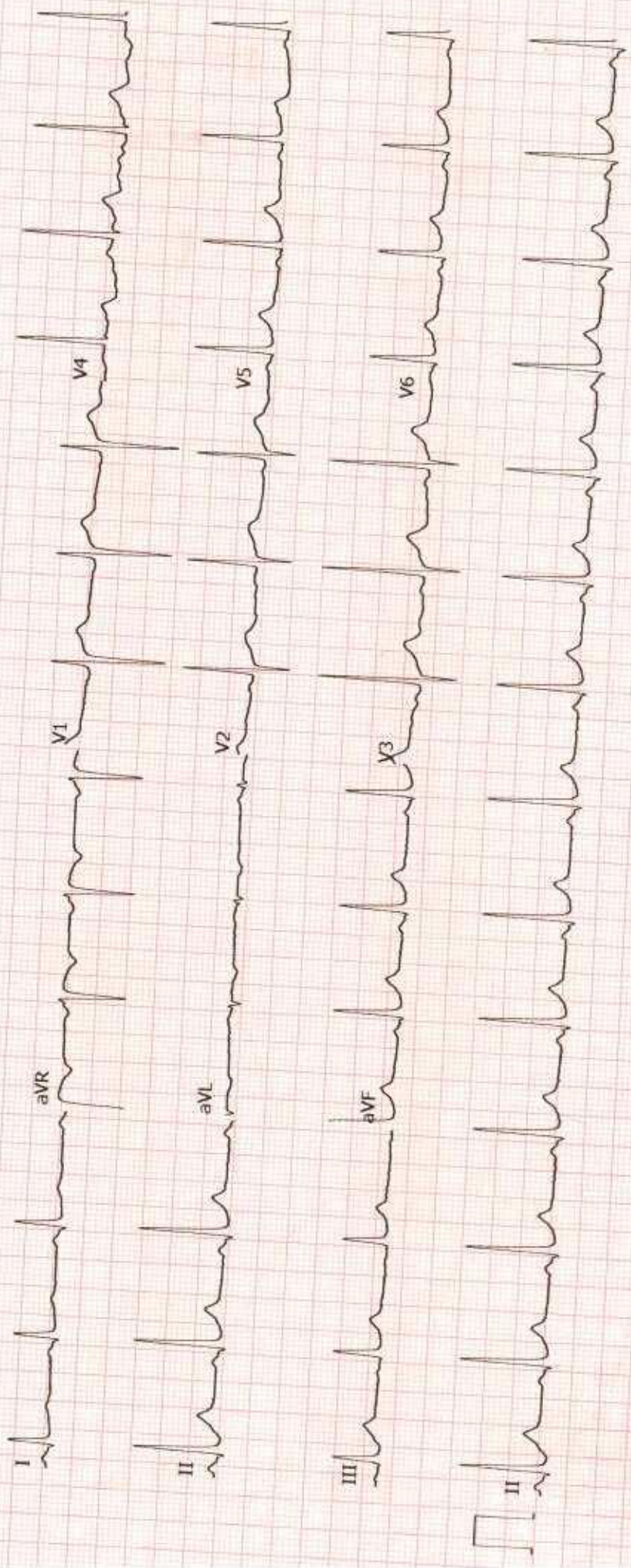
80 bpm
- / - mmHg

Chanchal Sharma

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

QRS : 80 ms
QT / QTcBaz : 362 / 417 ms
PR : 114 ms
P : 76 ms
RR / PP : 752 / 750 ms
P / QRS / T : 43 / 60 / 72 degrees

Normal sinus rhythm
Moderate voltage criteria for LVH, may be normal variant
Borderline ECG



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



SARDAR
PATEL HOSPITAL
& HEART INSTITUTE

Chikwadi, Opp. Railway Yard, Ankleshwar - 393 001 ☎ : 247882 / 247883

તારીખ : 11/4/23

નામ : chanchan sharma

	R				L			
	Sph.	Cyl.	Axis.	V/A	Sph.	Cyl.	Axis.	V/A
D. V.	3.0	0.50	30'	6/6	2.75	1.0	145'	6/6
N. V.	2.0	0.50	30'	12/6	1.75	1.0	145'	12/6

REMARKS :

FOR CONSTANT / DISTANCE / NEAR USE
Bifocals / Two separate pairs

Progressive

SIGN. (A)

નોંધ : આ કાગળ સાચવીને રાખશો અને ફરીથી તપાસ માટે આવો ત્યારે સાથે લાવવો.

Age / Gender : 42 years / Male

Patient ID : 21280

Source : Sardar Patel Hospital (OPD)

Referral : Dr Mediwheel Full body Health Checkup

Collection Time : 25/03/2023, 09:49 AM

Reporting Time : 25/03/2023, 01:34 PM

Sample ID :



002108423

Test Description	Value(s)	Unit(s)	Reference Range
CBC			
Complete Blood Count (CBC)			
Hemoglobin (Hb)* Method : Cymeth Photometric Measurement	14.2	gm/dL	13.5 - 18.0
Erythrocyte (RBC) Count* Method : Electrical Impedance	4.84	mil/cu.mm	4.7 - 6.0
Packed Cell Volume(Hematocrit) Method : Calculated	42.0	%	42 - 52
Red cell Indices			
Method - Calculated/Electrical Impedance			
MCV	86.78	fL	78 - 100
MCH	29.34	pg	27 - 31
MCHC	33.81	gm/dL	32 - 36
RDW - CV	13.3	%	11.5 - 14.0
Total and Differential count			
Method - Electrical Impedance and VCSN Technology			
Total Leucocytes (WBC) Count*	7600	cell/cu.mm	4000-10000
Neutrophils	65	%	40 - 80
Lymphocytes	25	%	20 - 40
Monocytes	07	%	2 - 10
Eosinophils*	03	%	1 - 6
Basophils	00	%	0 - 2
Platelet Count Method : Electrical Impedance	217	10 ³ /ul	150 - 450
Sample Type : EDTA Whole Blood.			
E.S.R			
Erythrocyte Sedimentation Rate Method : EDTA Whole blood, modified westergren	10	mm/hr	<15

Interpretation:

It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever.. It is also increased in multiple myeloma, hypothyroidism.

END OF REPORT

Bholiya

Dr. Bhavika Dholiya
M. D. Pathology
Registration No: G-32571

Scan to Validate



Patient Name : MR. CHANCHAL SHARMA

Age / Gender : 42 years / Male

Patient ID : 21280

Source : Sardar Patel Hospital (OPD)

Referral : Dr Mediwheel Full body Health Checkup

Collection Time : 25/03/2023, 09:49 AM

Reporting Time : 25/03/2023, 01:33 PM

Sample ID :



Test Description	Value(s)	Unit(s)	Reference Range
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BLOOD GROUP & RH (D) FACTOR, EDTA WHOLE BLOOD

Blood Group

Method : Forward and Reverse By Tube Method

"O"

RH Factor

Positive

Methodology

This is done by forward and reverse grouping by tube Agglutination method.

Interpretation

Newborn baby does not produce ABO antibodies until 3 to 6 months of age. So the blood group of the Newborn baby is done by ABO antigen grouping (forward grouping) only, antibody grouping (reverse grouping) is not required. Confirmation of the New-born's blood group is indicated when the A and B antigen expression and the isoagglutinins are fully developed (2-4 years).

END OF REPORT

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Age / Gender : 42 years / Male

Patient ID : 21280

Source : Sardar Patel Hospital (OPD)

Referral : Dr Mediwheel Full body Health Checkup

Collection Time : 25/03/2023, 09:49 AM

Reporting Time : 25/03/2023, 12:09 PM

Sample ID :



Test Description	Value(s)	Unit(s)	Reference Range
BLOOD GLUCOSE FASTING (FBS)			
Glucose fasting Method : GOD-POD	116.8	mg/dL	Normal: 70 - 99 Impaired Tolerance: 100-125 Diabetes mellitus: \geq 126 (on more than one occasion) (American diabetes association guidelines 2018)
Urine Fasting	Absent		
BLOOD GLUCOSE POST PRANDIAL (PP2BS)			
Blood Glucose-Post Prandial Method : GOD-POD	137.5	mg/dL	70 - 140
Urine Post Prandial	Absent		
GLYCOSYLATED HB (HBA1C)			
Glyco Hb (HbA1C)	5.6	%	Non-Diabetic: \leq 5.6 Pre Diabetic: 5.7-6.4 Diabetic: \geq 6.5
Estimated Average Glucose :	114.02		mg/dL

Interpretations

- HbA1C has been endorsed by clinical groups and American Diabetes Association guidelines 2017 for diagnosing diabetes using a cut off point of 6.5%
- Low glycated haemoglobin in a non diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency and haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
- In known diabetic patients, following values can be considered as a tool for monitoring the glycemc control.
Excellent control-6-7 %
Fair to Good control - 7-8 %
Unsatisfactory control - 8 to 10 %
Poor Control - More than 10 %

****END OF REPORT****

B. Dholiya

Dr. Bhavika Dholiya
M. D. Pathology
Registration No: G-32571

Scan to Validate



Age / Gender : 42 years / Male

Patient ID : 21280

Source : Sardar Patel Hospital (OPD)

Referral : Dr Mediwheel Full body Health Checkup

Collection Time : 25/03/2023, 09:49 AM

Reporting Time : 25/03/2023, 12:03 PM

Sample ID :



002108423

Test Description	Value(s)	Unit(s)	Reference Range
URINE ROUTINE			
Volume*	20	ml	ml -
Colour*	Pale Yellow		Pale Yellow
Transparency (Appearance)*	Clear		Clear
Deposit*	Absent		Absent
Reaction (pH)*	6.0		4.5 - 8
Specific Gravity*	1.015		1.010 - 1.030
Chemical Examination (Automated Dipstick Method) Urine			
Urine Glucose (sugar)*	Absent		Absent
Urine Protein (Albumin)*	Absent		Absent
Urine Ketones (Acetone)*	Absent		Absent
Blood*	Absent		Absent
Bile pigments*	Absent		Absent
Nitrite*	Absent		Absent
Microscopic Examination Urine			
Pus Cells (WBCs)*	Occasional	/hpf	0 - 5
Epithelial Cells*	Absent	/hpf	0 - 4
Red blood Cells*	Absent	/hpf	Absent
Crystals*	Absent		Absent
Cast*	Absent		Absent
Trichomonas Vaginalis*	Absent		Absent
Yeast Cells*	Absent		Absent
Amorphous deposits*	Absent		Absent
Bacteria*	Absent		Absent

END OF REPORT

B. Dholiya

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Test Description	Value(s)	Unit(s)	Reference Range
LIVER FUNCTION TEST-1			
Bilirubin - Total Method : Diazoization	0.54	mg/dL	0.3 - 1.2
Bilirubin - Direct Method : Serum, Diazoization	0.23	mg/dL	Adults and Children: 0.0 - 0.4
Bilirubin - Indirect Method : Calculated	0.31		
SGOT Method : Serum, UV without P5P	26.9	U/L	< 50
SGPT Method : Serum, UV without P5P	37.8	U/L	< 50
Alkaline Phosphatase-ALPI Method : Serum, PNPP, AMP Buffer, IFCC 37 degree	116.0	U/L	30-120
Total Protein Method : Serum, Buret, reagent blank end point	6.61	g/dL	6.6 - 8.3
Albumin Method : Serum, Bromocresol green	3.85	g/dL	Adults: 3.5 - 5.2
Globulin Method : Calculated	2.76	g/dL	1.8 - 3.6
A/G Ratio Method : Calculated	1.39	ratio	1.2 - 2.2
RENAL PROFILE			
Urea * Method : Serum, Urease	32.3	mg/dL	17- 55 mg/dL
Creatinine* Method : Serum, Enzymatic	1.39	mg/dL	0.6 - 1.4 mg/dL
Uric Acid* Method : Serum, Uricase/POD	9.7	mg/dL	3.5 - 7.2
Blood Urea Nitrogen-BUN* Method : Calculated	15.09	mg/dL	7 - 25 mg/dL
Calcium* Method : Arsenazo III	9.38	mg/dL	8.8 - 10.8
Sodium* Method : Serum, Indirect ISE	139.1	mmol/L	136 - 146
Potassium* Method : Serum, Indirect ISE	4.56	mmol/L	3.5 - 5.1
Chloride* Method : Serum, Indirect ISE	106.9	mmol/L	97.0 - 108.0

END OF REPORT

Bhaliya

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Registration No: G-32571

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Age / Gender : 42 years / Male

Patient ID : 21280

Source : Sardar Patel Hospital (OPD)

Referral : Dr Mediwheel Full body Health Checkup

Collection Time : 25/03/2023, 09:49 AM

Reporting Time : 25/03/2023, 12:37 PM

Sample ID :



002108423

Test Description	Value(s)	Unit(s)	Reference Range
LIPID PROFILE (D)			
Cholesterol-Total Method : Serum, Cholesterol oxidase esterase, peroxidase	218.0	mg/dL	Desirable: <= 200 Borderline High: 201-239 High: > 239
Triglycerides Method : Serum, Enzymatic, endpoint	388.26	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500
Cholesterol-HDL Direct Method : Serum, Direct measure-PEG	37.9	mg/dL	Normal: > 40 Major Heart Risk: < 40 Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190
LDL Cholesterol Method : Calculated	102.45	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL
Non - HDL Cholesterol, Serum Method : calculated	180.10	mg/dL	6 - 38
VLDL Cholesterol Method : calculated	77.65	mg/dL	3.5 - 5.0
CHOL/HDL RATIO Method : calculated	5.75	ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0
LDL/HDL RATIO Method : calculated	2.70	ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0
HDL/LDL RATIO Method : calculated	0.37	ratio	

Note: 8-10 hours fasting sample is required. Test results may show interferences due to pregnancy, certain drugs such as estrogens and other drugs (such as androgenic and related steroids), and insulin therapy etc. 12 hours fast is recommended prior to the test as non fasting status may result in falsely elevated test values. Alcohol should not be consumed for atleast 24 hours before the test. Values may be increased in acute illness, colds or flu. Obesity, stress, physical inactivity, cigarette smoking may lead to increase test values. If possible all medications should be withheld for atleast 24 hours before testing (On Doctors Advice). Intraindividual variations, seasonal as well as positional variations (levels lower when sitting compared to standing etc.) have been observed. Cholesterol and HDL-C should not be measured immediately after MI, and 3 months wait is suggested.

END OF REPORT

B. Dholya

Dr. Bhavika Dholya
M. D. Pathology
Registration No: G-32571

Scan to Validate



Age / Gender : 42 years / Male

Patient ID : 21280

Source : Sardar Patel Hospital (OPD)

Referral : Dr Mediwheel Full body Health Checkup
Maharashtra | Goa | Gujarat

Collection Time : 25/03/2023, 09:49 AM

Reporting Time : 25/03/2023, 12:47 PM

Sample ID :



002108423

Test Description	Value(s)	Unit(s)	Reference Range
THYROID FUNCTION TEST 1			
T3-Total Method : Serum, CLIA	1.13	ng/mL	0.69 - 2.15 ng/mL
T4-Total Method : Serum, CLIA	4.32	ug/dL	5.2 - 12.7 ug/dL
TSH Method : Serum, CLIA	6.60	uIU/mL	0.3 - 4.5 uIU/mL

Interpretation

END OF REPORT

Dr. Bhavika Dholiya
M. D. Pathology
Registration No: G-32571

Scan to Validate



Patient Name:-	CHANCHAL SHARMA	Date :-	25/03/2023
Age & Sex :-	42Y M		
Referred By :-	HEALTH CHECK UP		

X-RAY CHEST PA VIEW

Both lung zones are clear.

Cardiac silhouette is normal

Both costophrenic angles are clear.

Both domes of diaphragm are at normal level.

Bony thorax is unremarkable

Impression-No significant abnormality in present study.

Please correlate with clinical findings and relevant investigations.



Dr. Vivek Chaudhari
D.M.R.E.
Consultant Radiologist

Patient's Name:-	CHANCHAL SHARMA		
Age & Sex :-	42Y	M	DATE
Referred By :-	HEALTH CHECKUP		
			01/04/2023

USG ABDOMEN & PELVIS

LIVER : normal in size shape and normal echotexture.
No focal solid or cystic mass seen.

Portal & biliary radicals normal.

PV & CBD normal.

G.B. : well distended & normal. No stone or inflammation seen.

PANCREAS : visualised reveals normal echotexture. No mass, calcification or pancreatitis.

SPLEEN : Normal size & reveals normal echotexture. No other focal mass seen.

LEFT KIDNEY : (102 X 45) mm in sized and show mild fullness in left pelvicalyceal system. left ureter appear non dilated.

Left kidney show mild cortical irregularity.

Right renal fossa appear empty, **right kidney not visualized, P/ o Absent/ atrophic right kidney.**

No focal solid or cystic mass seen. No calculus.

C.M differentiation is preserved. No parenchymal abnormality seen.

U. BLADDER : Well distended & normal. No mass or filling defect seen.

PROSTATE: Normal in size (16 cc) & echotexture. No mass or calcification seen.

BOWEL LOOPS : peristaltic bowel loops seen in lower abdomen. Bowel loops are normal calibre (Visualized).

No free fluid seen. No enlarged lymphnodes seen.

IMPRESSION:

Absent/ atrophic right kidney with compensatory hypertrophy of left kidney.


DR. CHAITALI
MDRD

Thanks for reference. Please co-relate clinically.

Note: This report is not valid for medico-legal purpose. There can be typing error, which can be correctable.

Sonography has its own limitation. Clinical Correlation and Further Invention If Needed Clinically.



2D ECHO CARDIOGRAPHY REPORT

SARDAR PATEL HOSPITAL
& HEART INSTITUTE

Name : Mrs chanchal sharma

UHID : 4176

Age / Sex : 42 Yrs. /m

Date : 25.3.2023

Done By: Dr. Milan Mehta

- All cardiac chambers are normal in dimension
- Normal LV Systolic function at Rest, LVEF = 60 %
- No RWMA at Rest.
- Grade I LV diastolic dysfunction
- MV – Normal, No MS/ Trivial MR AV –mildly sclerotic, No AS/Mild AR
- TV – Normal , No TS/ Trivial TR PV – No PS / PR
- No significant Pulmonary Hypertension, RVSP = 30 mmHg
- IAS / IVS appear Intact
- No e/o Clot / Vegetation /pericardial effusion
- IVC normal diameter and collapse > 50 % with respiration

IMPRESSION: NORMAL LVEF, NO RWMA, GRADE I LVDD

Dr. Milan Mehta
D.Card (Mumbai)
Non-Invasive cardiology

Dr. Jayveer Atodariya
MD, DM, CARDIOLOGY
Consultant: Interventional Cardiology

Sardar Patel Hospital & Heart Institute

Chikuwadi, Opp, Railway Yard, Ankleshwar - 393001 | Phone: +91 2646 247882/83
Emergency: +91 72270 34848 | Email: info@sardarpatelhospital.com | www.sardarpatelhospital.com



OPD INITIAL ASSESSMENT FORM

(To be filled by Nursing Staff)

Patient Name: - Chamehel Sharma UHID Number: - 4126

Consultant Name: DR. Deepesh Vadodariya Date: 8/6/23 Start Time: - _____ Age: 42 (Years)

Sex: - M (M/F) Height: - _____ cms, Weight: - _____ kgs. Temp. _____, Pulse: - _____ (Per minute), SPO2 _____

B.P. :- _____ (mm of Hg), RBS: - _____

Visit: First visit First Visit / Follow Up (Perk)

Nursing Staff Name & Signature: - Sudhey End Time: - _____

Past History: - (TICK MARK)

Diabetes, Hypertension, IHD, COPD, Asthma, TB, Smoker, Alcoholic, Hypothyroidism

Other: - NO

Family History: - _____

Nutritional Screening: - _____

Psychosocial Assessment: - _____

Immunization Status: - _____

To be filled by Clinician) Start Time: - _____

Clinical Findings: - corse go Health check
no

Diagnosis: - _____

Investigations and Advice: -

no suggestion

(50) P/A - 50%
non-feder
RIP